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SEP 30 1970

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Massachusetts General Hospital

Dear Mr. Chairman:

Russell B. Long

Pursuant to your request of May 7, 1970 (enc. II), we are submitting a report (enc. I) on our review of Medicare payments made by the Massachusetts Medical Service (Blue Shield) for the services of supervisory and teaching physicians at the Massachusetts General Hospital in Boston, Massachusetts. These payments were made under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program.

This is the second report submitted pursuant to your May 7 request. A prior report concerning Medicare payments for the services of salaried supervisory and teaching physicians at Herman Kiefer Hospital in Detroit, Michigan, was submitted to the Committee on August 21, 1970.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various private insurance companies, such as Blue Shield organizations, for making benefit payments for physicians' services under part B.

Following is a summary of the information, obtained during our review at the Massachusetts General Hospital, relating to the points of interest specified in your letter of May 7.

--During the period October 30, 1967, through September 30, 1969, Blue Shield paid about $296,000 to the hospital under part B of the Medicare program for the services of supervisory and teaching physicans who were affiliated principally with the Harvard Medical School. The billings by the hospital were on a fee-for-service basis in the names of specific physicians for specific services provided to specific Medicare patients who were inpatients in the teaching service section of the hospital. (See pp. 2 to 9.)

--Our review of the hospital medical records applicable to selected Medicare patients treated in the teaching service section

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of the hospital and in the private patient sections of the hospital showed wide differences in the involvement of the physicians in whose name the claims were submitted in the specific services for which part B payments were made. SSA regulations state that, under part B of the Medicare program, a charge should be recognized for the services of an attending physician who involves residents and interns in the care of his patients only if his services to the patient are of the same character as the services he renders to his other paying patients.

Our examination of medical records of selected Medicare patients in the teaching service section of the hospital indicated that, for nonsurgical cases, the services paid for by Blue Shield were usually provided by residents and interns, rather than by the physicians in whose names the claims were submitted. For example, of the 746 charges for daily visits included in the payments we reviewed, the medical records showed that the physician in whose name the claims were submitted was involved in providing services on only 11 occasions, or less than 2 percent of the daily visits billed.

Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but their salaries were reimbursed to the hospital under the Hospital Insurance Benefits for the Aged (part A) portion of the Medicare program, which meant, in effect, that the program could be paying twice for the same service. (See pp. 10 to 15.)

For surgical cases involving Medicare teaching service patients, the physician in whose name the claim was submitted was present in the operating room for every case reviewed but medical records showed that, in most cases, a surgical resident had been designated as the principal surgeon. (See pp. 20 to 23.)

In contrast, our comparison of medical records of selected Medicare private patients with the hospital's medical records

showed that, for the daily visits billed, the billing physician had made notations in the medical records for about 59 percent of the daily visits billed. Also, for the surgical cases reviewed that involved private patients, the billing physician was shown in the medical records as the principal surgeon in every instance. (See pp. 29 to 33.)

-- In addition to indicating the lack of evidence of the involvement of the supervisory and teaching physicians in the specific services billed in their names, our review indicated that the hospital had other problems in complying with SSA guidelines outlining the circumstances under which payments for services rendered by supervisory and teaching physicians could be made.

1. According to the SSA guidelines, for the hospital to bill, the teaching physician must:

   "*** be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care at least throughout the period of hospitalization."

   At Massachusetts General Hospital, the assignments of supervisory and teaching physicians to the teaching service section of the hospital were not related to the period of the patients' hospitalization. Accordingly, services were billed in the names of supervisory and teaching physicians for periods during which the physicians were no longer assigned to the care of the patients. (See pp. 16 and 17.)

2. For claims for physicians' services rendered in one section of the hospital, there was a lack of evidence that the services had been provided. (See p. 18.)

-- The funds collected by the Massachusetts General Hospital under Medicare for the treatment of teaching service patients

were deposited into the Patient Care Improvement Fund administered by the hospital. About 55 percent of the funds collected through September 30, 1969, had been expended for specific purposes, such as salary supplements for the supervisory and teaching physicians. The remaining 45 percent had been transferred to the general funds of the hospital. (See p. 7 to 9.)

-- Generally the Medicare teaching service patients were not billed by the hospital for the coinsurance and deductible amounts. Also, of the 55 claims reviewed by us that had been submitted on behalf of teaching service patients, only nine had been signed by the patients, 13 by the patients' relatives, and 33 by hospital employees. Blue Shield, however, did notify the patients of the payments made on their behalf. (See p. 26.)

-- The basis for the hospital's charges to part B of the Medicare program on behalf of the teaching service patients was a uniform fee schedule initially developed by the hospital for private patients of moderate means. In our opinion, Blue Shield did not follow SSA instructions concerning the evaluation of the reasonableness of the fee schedule because there was no assurance that fees did not, in the aggregate, exceed the amounts that would have been charged if the physicians had billed separately. (See pp. 26 to 28.)

-- Except for surgical procedures and related care, only Medicare was billed professional fees for inpatient and outpatient medical services in the teaching service section of the hospital. Third-party insurers, other than Medicare, were not charged for comparable services. Blue Shield did honor claims for surgery under its medical insurance policies in certain circumstances. (See pp. 33 to 35.)

-- SSA, Blue Shield, and the hospital have been slow in complying with SSA's April 1969 guidelines which set forth the circumstances under which Medicare payments to supervisory and

teaching physicians could be made. In June 1969, Blue Shield furnished these guidelines to the 58 teaching hospitals in the State of Massachusetts. In August 1969, Blue Shield suspended part B payments to these hospitals, including Massachusetts General Hospital, pending an audit of the claims at each hospital. Blue Shield's initial audit at Massachusetts General Hospital was made in October 1969. On the basis of this audit, Blue Shield concluded that the supervisory and teaching physicians at the hospital were performing the services for which claims were being submitted under part B and resumed payments to the hospital.

Blue Shield, however, did not retain any working papers and did not know the names of the Medicare patients whose medical records had been examined. Because the results of Blue Shield's October 1969 audit differed substantially from the results of our review, we made inquiries of Blue Shield officials and learned that it was likely that Blue Shield had examined mostly surgical cases or claims for services to private patients. Subsequently, Blue Shield made another audit at the hospital involving claims for services to patients in the teaching service section of the hospital and found essentially the same types of problems as we did in our review.

In March 1970, or about a year after the issuance of SSA's guidelines, Blue Shield issued its implementing instructions to the teaching hospitals in Massachusetts to further clarify the conditions which must be met for supervisory or teaching physicians to be paid for professional services to individual patients under part B of the Medicare program.

SSA advised us that in May 1970 it had recommended to Blue Shield that further payments to the hospital be suspended until Blue Shield could establish that reimbursements were for covered services and at the proper rates. SSA and Blue Shield also stated that another audit of prior payments to the hospital was being made to establish the extent of any possible overpayments. On July 15, 1970, Blue Shield again resumed making payments for surgical cases and for outpatient clinical visits but not for inpatient medical services.

In commenting on a draft of this report, the hospital pointed out that, inasmuch as SSA's April 1969 guidelines had not been published in the Federal Register, they could not be considered regulations.

The underlying purpose of the Federal Register Act (44 U.S.C. 1501) is to afford a basis for giving constructive notice of Government regulations. The SSA guidelines were received by the Massachusetts General Hospital by July 1969, and the hospital therefore would be chargeable with knowledge of such guidelines in the same manner as if they had been published in the Federal Register. (See pp. 36 to 39.)

In February 1970, the staff of your Committee on Finance issued a report to the Committee in response to its directive that the staff make a study of the status and operations of the Medicare and Medicaid programs. Among the items discussed in the staff report was the matter of payments under the Medicare program to supervisory and teaching physicians in teaching hospitals. The staff report pointed out that there was a distinction in the doctor-patient relationship between a private patient and an institutional or teaching service patient. Partially because of this distinction, the staff report questioned the appropriateness of the Medicare program's making payments on a fee-for-service basis for supervisory services rendered by teaching physicians in teaching hospitals.

On May 21, 1970, the House of Representatives passed House Bill 17550, entitled "Social Security Amendments of 1970." One of the provisions of the bill would change the basis of reimbursement for supervisory and teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis when the physicians' services are furnished in a setting containing either of the following circumstances.

1. The non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services.

2. Some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges.

We believe that our report on Medicare payments for services rendered by supervisory and teaching physicians in the Massachusetts General Hospital will be of particular interest to the Committee because it supports the point made in the February 1970 Committee staff report that there are differences in the extent of the personal involvement of attending physicians in the care of their private patients and in the care of their teaching service patients. Also, with respect to the payments we reviewed, these differences had not been taken into consideration in determining the basis for and amounts of reimbursements made under the Medicare program.

The matters discussed in the report were presented to SSA, Blue Shield, and the hospital for review. Their written comments were considered by us in the preparation of our report.

Pursuant to agreement with the Committee staff, copies of the report are being sent to the Chairman of the House Committee on Ways and Means; the Secretary of Health, Education, and Welfare; and other appropriate officials of the Department of Health, Education, and Welfare.

Sincerely yours,

Comptroller General
of the United States

Enclosures - 2

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

GENERAL ACCOUNTING OFFICE

EXAMINATION INTO

MEDICARE PAYMENTS FOR SERVICES OF

SUPERVISORY AND TEACHING PHYSICIANS AT

THE MASSACHUSETTS GENERAL HOSPITAL

BOSTON, MASSACHUSETTS

INTRODUCTION

The Medicare health insurance program was established under title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966. The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various insurance companies, such as Blue Cross and Blue Shield organizations, for making benefit payments under the program.

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, as well as posthospital care in an extended-care facility or in the patient's home. Payments for this protection are made from a trust fund financed through a social security payroll tax. Blue Cross is the principal organization in Massachusetts making benefit payments under part A.

The second form, designated as Supplementary Medical Insurance Benefits for the Aged (part B), covers physicians' services. Part B benefits are paid from a trust fund financed through premiums paid by beneficiaries electing to participate and matching contributions from funds appropriated by the Federal Government. Effective April 1, 1968, the monthly premium was increased from $3 to $4; effective July 1, 1970, the premium was increased to $5.30. The beneficiary is responsible for paying the first $50 (deductible) for covered services in each year and 20 percent of the

reasonable charges in excess of the first $50 (coinsurance). Massachusetts Medical Service (Blue Shield) is the principal organization making part B benefit payments in Massachusetts.

Payments to supervisory and teaching physicians

Payments to supervisory and teaching (visiting) physicians at teaching hospitals are allowed by SSA regulations under part B. SSA regulations issued on August 31, 1967, stated that to qualify, the physician must be the Medicare patient's attending physician and either render services personally or provide "personal and identifiable direction to residents and interns" participating in the care of his patient. The salary costs of hospital residents and interns under an approved training program are reimbursed to the hospital under part A. In April 1969, SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payments for services of supervisory and teaching physicians.

MEDICAL CARE AT THE MASSACHUSETTS GENERAL HOSPITAL

The Massachusetts General Hospital (MGH) is a privately incorporated teaching hospital that receives funds for patient care from patients and from third-party insurers, both governmental and commercial. The hospital receives funds also through Government research grants and private contributions and endowments.

MGH consists of three main divisions: Phillips House, a unit for private patients of physicians on the MGH staff; Baker Memorial Hospital which has both private and semiprivate accommodations for private patients of moderate means; and the general hospital wards which are for the care of service patients generally classified as those patients who are unable to pay the MGH charges and professional fees of other units of MGH. The service patients have been MGH's principal source of patients used in teaching programs for residents and interns.

MGH has about 1,070 beds, of which 582 are for private patients and 488 are for teaching service patients. There

are instances in which private patients may be housed in the service sector of MGH and teaching service patients may be housed in the private sector. This would be the case when either the private sector or the service sector could not accommodate patients normally housed in its area.

Our review of MGH records indicated that medical care in the private sector of MGH was primarily the responsibility of staff physicians with some assistance from residents and interns. The records indicated that, in the service sector, the staff of residents and interns rendered most of the medical care, with overall supervision provided by a staff of supervisory and teaching physicians.

For the fiscal year ended September 30, 1969, the hospital reported 355,921 inpatient days, of which 100,112, or 28 percent, were for Medicare patients. The inpatient costs for the year were about $36.6 million, of which about $10.6 million, or 29 percent, applied to Medicare patients. The outpatient costs for the same period amounted to about $7.4 million, of which about $1 million, or 14 percent, applied to Medicare patients.

MGH provides a wide range of services, such as surgery, gynecology, pediatrics, and medical services, and operates about 70 general and specialty clinics. In November 1969, the hospital reported that the staff included 787 staff physicians, 300 residents and interns, and 300 clinical and research fellows.

Affiliation with
Harvard Medical School

MGH and six other hospitals in Boston are affiliated with the Harvard Medical School. Under this affiliation, the hospitals have the primary responsibility for the care of patients and for the prevention and treatment of disease. Efforts are made, however, to ensure that a large proportion of the school's faculty members are associated with one or more of the affiliated hospitals and that a large proportion of those physicians holding the more responsible positions in the hospitals are active members of the school's faculty.

According to the associate dean of the school, about 75 percent of the staff physicians of MGH are on the school's faculty.

Compensation of physicians

Physicians, other than residents and interns who are salaried employees of MGH, have various arrangements with MGH for their compensation. Generally those involved in internal medicine bill their private patients direct for services rendered in the hospital. Surgeons bill their private patients and either retain the monies received or, if they are members of the MGH Surgical Associates, remit the monies to MGH which administers a fund for the member surgeons.

All MGH staff radiologists are members of Radiological Associates, and billings for radiology services are made by the association. The association turns over all monies received for professional services to the hospital which pays the radiologists' salaries. Hospital officials estimated that about 10 percent of the monies generated by Radiological Associates each year is donated to MGH.

In return for hospital privileges, physicians are expected to donate between 150 and 200 hours a year to various MGH activities, such as the outpatient clinics, or as members of the visiting staff. These physicians may be compensated by the hospital for time spent over and above these hours, and, as subsequently discussed in more detail, professional fees earned from the care of teaching service patients have been used as a source for such compensation.

Visiting staff

At MGH the supervisory and teaching physicians in the teaching service section of the hospital have been designated as the visiting staff and are responsible for (1) supervising the care furnished to service patients by the interns and residents and (2) teaching the residents, interns, and medical students. Usually these visiting physicians have designated tours of duty on the teaching service of the hospital of 1 calendar month at a time. At the end of each month, exchange rounds are conducted, during which visiting physicians who have completed their tours of duty relinquish the responsibilities to the physicians beginning their tours.

The visiting physicians are assigned to the various medical and surgical areas of the hospital, such as medical, general surgery, children's service, orthopedics, and urology. For example, 24 visiting physicians covered the service areas during the month of March 1970.

We discussed the duties, responsibilities, and working routine of these visiting physicians with the hospital's chief of medical service. He informed us that the visiting physicians made rounds from about 10 a.m. to 1 p.m. 6 days a week, during which they, together with the residents and interns, examined patients. The visiting physicians also provided supervision and oversaw the medical care being rendered. They were on call for emergencies at other times. The chief stated that they generally devoted, on the average, 45 minutes to each new patient admitted to the hospital during the preceding 24 hours.

At the invitation of hospital officials, we accompanied a visiting physician, a resident, and two interns on their medical service rounds which took about 3 hours. Medicare and non-Medicare patients were housed in the same wards. The degree of the visiting physician's involvement varied considerably from patient to patient. Some patients were not in bed at the time of the rounds and thus were not seen by the visiting physician. Other patients were carefully examined, particularly if it was the first time the visiting physician had seen them, but still others were passed with a nod of acknowledgment. The visiting physician discussed all patients with the resident and interns. We observed that the visiting physician did not make notations in the medical records.

The chief of surgery stated that the involvement of a visiting physician on the surgical service in the care of inpatients varied. He added, however, that Medicare part B was not billed unless (1) the visiting physician was present during surgery, (2) his presence was considered necessary, and (3) he participated in the preoperative and postoperative care of the patient.

MEDICARE PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

Policy of MGH

In a letter dated October 30, 1967, to the visiting physicians, the director of MGH announced a policy, approved by the MGH board of trustees, concerning the collection of fees from third-party insurers by ~~such~~ physicians for their services rendered to teaching service patients. The director described the policy as a somewhat radical departure from practices existing at MGH at that time but stated that he thought it desirable in order to cope with the changes evolving in the structure of medical care in teaching hospitals brought about by recent social legislation.

Each visiting physician was given an option of (1) certifying to MGH that a billable professional service had been rendered and preassigning the fee to MGH, (2) electing to not certify, or (3) collecting the fee for his personal use. The director stated that the MGH general executive committee felt that it would not be in the best interest of MGH, its patients, or the public at large if the visiting physicians elected to collect the fees for their personal use.

Physicians who elected to certify a professional fee were requested to sign an assignment of their fees, as follows:

> "I, as a member of the M.G.H. Service, hereby voluntarily assign to the Massachusetts General Hospital all professional fees collected from teaching service patients in my behalf. This agreement is to be effective until terminated by me or by the hospital by written notice to the other, given at least sixty days prior to date of termination stated in the notice."

According to MGH officials, about 300 visiting physicians elected to assign to MGH their fees for services rendered to teaching service patients. We found no instances in which visiting physicians had charged Medicare part B for services to teaching service inpatients included in our sample without preassigning the fees to MGH.

MGH officials acknowledged to us that it was difficult to distinguish between teaching services and patient care provided by visiting physicians in a teaching setting. The director of MGH advised us that it was the responsibility of the visiting physicians, by exercising judgment on a case-by-case basis, to decide the extent to which their services justified fees.

Not all Medicare patients billed

The MGH comptroller advised us that MGH did not bill Medicare for the services provided by visiting physicians to all Medicare patients in the teaching service section of MGH. The comptroller suggested that Medicare was billed professional fees for perhaps only one third of the Medicare patients. Our review confirmed that all services of visiting physicians provided to Medicare patients in the teaching service section of MGH had not been billed for by the hospital. This seems to indicate that physicians did use discretion in deciding which Medicare patients in the teaching service section would be billed.

Our analysis of MGH admission data for the 1-week period August 18 through August 24, 1969, showed that 60 patients eligible for part B benefits had been admitted to the teaching service section of MGH. As of March 26, 1970, the hospital had billed only 18 (30 percent) of the 60 patients for services of visiting physicians.

There were various reasons why Medicare teaching service patients were not charged fees under part B. According to MGH officials, the services rendered in some instances clearly did not meet the criteria for reimbursement under the Medicare program. For example, in minor surgical cases only residents were present during the surgery. In other cases, either the chiefs of the services or the visiting physicians did not believe that fees should be charged for the type of services rendered.

PATIENT CARE IMPROVEMENT FUND

Effective October 30, 1967, MGH established the Patient Care Improvement Fund to accumulate the professional fees collected by MGH for services provided by visiting physicians and

for related ancillary services, such as radiology and electrocardiography.

It is the policy of MGH that service patients are not expected to pay for professional fees. Fees are collected, however, from third-party insurers. Also it is the policy of MGH to not collect the $50-deductible or the 20-percent-coinsurance amounts from Medicare service patients.

From its inception through September 30, 1969, $580,000 was deposited into the fund, of which about $470,000 represented Medicare part B payments and about $110,000 represented payments from other third-party insurers for surgical services.

Source of Receipts of
Patient Care Improvement Fund
through September 30, 1969

	Total	Medicare part B	Other third-party insurers
Inpatient services:			
Medical	$156,000	$156,000	$ -
Surgical	250,000	140,000	110,000
	406,000	296,000	110,000
Outpatient services	33,000	33,000[a]	-
Ancillary services	141,000	141,000[a]	-
	$580,000	$470,000	$110,000

[a]About $116,000 of this amount represented transfers to the fund from Radiological Associates for the professional (part B) component of radiological services furnished to Medicare service patients. Of the remaining $25,000 in Medicare payments for ancillary services, $21,000 was for electrocardiograms, and the balance was for miscellaneous services furnished to Medicare patients.

MGH records showed that, of the $580,000 received as of September 30, 1969, about $332,000 had been expended for specific purposes--$246,000 for salaries to physicians,

$44,000 for salaries to clerical personnel and technicians, $32,000 for related fringe benefits, and $10,000 for other expenses.

The remaining $248,000 received by the fund was transferred to the general funds of MGH. The accounting treatment of these funds was similar to the treatment of unrestricted donations for which there is no requirement to reduce allowable costs under SSA's reimbursement regulations established for part A of the Medicare program. The $332,000 spent for specific purposes was not included as allowable hospital costs for reimbursement purposes under part A.

Of the $246,000 paid to physicians, about $186,000 was paid to 39 physicians who had assigned their fees to the fund and about $60,000 was paid to 14 physicians who had not made such assignments.

The general guidelines established by MGH for use of the money in the fund provided that (1) under ordinary circumstances, a physician would not be paid more than $7,500 yearly, (2) each physician who received salary support from the fund must have a written description of how his activities would help improve the professional care of the patients, and (3) payments for the improved care of patients would be made only for services of physicians in excess of the 150 to 200 hours a year that they were expected to donate in exchange for hospital privileges. The director of MGH informed us that there was no relationship between MGH's payments to a visiting physician from the fund and that physician's decision to bill or not to bill as an attending physician.

REVIEW OF MEDICAL RECORDS FOR SERVICES RENDERED BY VISITING PHYSICIANS

Our review of medical records of selected patients in the teaching service section of MGH indicated that the professional services for which Medicare payments had been made by Blue Shield to MGH for services of visiting physicians generally had been furnished by interns, residents, and in some cases medical students rather than by the physicians in whose names the claims had been submitted. Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but, their salaries were reimbursed to MGH under part A of the program, which means, in effect, that the program could be paying twice for the same service.

We were informed by MGH officials that individual medical records did not fully reflect the actual involvement of the visiting physicians in the care of individual patients and that the medical records were not accounting records that purported to be the basis for billings for services. The rules of the board of trustees of MGH, however, indicated that a physician who rendered or supervised medical services should document these services in the medical records. Excerpts from these rules follow.

> "Medical Records: (a) A complete medical record shall be created for each patient. The Chief of the Service or Department concerned shall be responsible for seeing that this is done. The physician responsible for each individual patient shall record in the medical record notes of his own examination, opinion and recommended treatment."
>
> * * * * *
>
> "(d) An admission note shall be written by the responsible physician as soon as possible after admission. Within 24 hours he must record the patient's history, complete physical examination, summary and provisional diagnosis. If the history and physical examination are recorded promptly the admission note is unnecessary."

* * * * *

"(g) A brief summary of the entire case shall be dictated or written by the responsible physician upon discharge of the patient.

"(h) The attending physician shall edit, correct or amend and countersign the history, physical examination and summary written by members of the House Staff. He shall sign all clinical entries made by himself."

* * * * *

"(j) All operations shall be fully described in the medical record and signed by the operating surgeon."

SSA's April 1969 guidelines regarding part B payments for services of visiting physicians state that, to be paid, the physician's involvement "must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician."

MGH billings on behalf of visiting physicians were made payable to the Patient Care Improvement Fund for a range of services, including medical and surgical care rendered to service patients in MGH and various ancillary services, such as radiology. We reviewed selected payments totaling $11,243 made by Blue Shield from December 1967 to December 1969 to the Patient Care Improvement Fund for services provided to 55 teaching service Medicare inpatients and 26 Medicare outpatients (51 outpatient claims).

In compiling the results of our sample, we separated the data on the basis of service dates to determine the extent to which documentation evidencing that visiting physicians had been involved in rendering the specific services billed had increased with the advent of SSA's April 1969 guidelines regarding part B payments to visiting physicians. We used July 17, 1969, as our cutoff date, since that was the date when MGH distributed the guidelines to each chief of service and, in our opinion, should have implemented the guidelines. (See p. 36.)

Because of the technical nature of the data being examined, we were assigned a Public Health Service physician to assist us in our review. The following table summarizes the nature and number of services involved, as well as the amounts billed to and allowed by Blue Shield, for the billings we reviewed.

Inpatient and Outpatient Billings

	Occasions of service	Amounts billed	Amounts allowed by Blue Shield
Inpatient billings:			
Medical services:			
Initial medical care	36	$ 1,440	$ 925
Daily visits	746	7,560	7,440
Consultations	9	360	315
Total medical services	791	9,360	8,680
Surgical services requiring use of operating room	13	5,325	5,155
Total inpatient billings	804	14,685	13,835
Outpatient billings	51	510	510
Total	855	$15,195	14,345
Less deductibles and coinsurance payable by beneficiaries			3,102
Total payments reviewed			$11,243

Our findings are discussed in the following subsections.

Initial medical care

On admission to the teaching service section of the hospital, a patient was generally provided with initial medical

care which, according to MGH's guidelines, consisted of "a comprehensive diagnostic history and physical examination including initiation of diagnostic and treatment program and preparation of hospital records." For billing purposes, this medical care was classified as an initial visit and a charge of $40 was made for each of 36 of the 42 nonsurgical teaching service patients included in our sample. Generally Blue Shield allowed $25 for the initial visit. In each of the remaining six cases, a charge of $40 was made for consultation, instead of initial medical care, for the initial day of hospitalization.

The number and type of medical personnel identified as having been involved in rendering specific services during initial visits are summarized in the following table. In 18 of the 36 cases, the medical records showed that the visiting physicians in whose names the services had been billed were personally involved in providing the specific services billed. In most cases, more than one person was identified as having been involved in providing the same service. Therefore the number of medical personnel identified with the services exceeded the total occasions of service billed.

		Nonsurgical cases	
	Total	Service rendered on or before July 17, 1969	Service rendered after July 17, 1969
Occasions of service rendered and billed	36	16	20
Medical personnel identified in the records with the service:			
Visiting physicians same as identified on bill	18	6	12
Residents	51	21	30
Interns	25	8	17
Medical students	16	6	10
Records not signed or signature not identifiable	10	5	5
Total	120	46	74

In addition to describing the $40 initial visit fee, MGH's guidelines for setting reasonable fees, described the services covered by an initial visit fee of $20, as follows:

> "Initial hospital care, including initiation of diagnostic and treatment program and preparation of hospital records."

The two types of initial visits differed in that the visit for which a $40 fee was charged included a diagnostic history and physical examination. In all 36 claims reviewed, the charges for initial medical care were routinely billed at $40 each, instead of $20, even though the medical records indicated that residents and interns, rather than visiting physicians, had performed the diagnostic histories and physical examinations.

Daily medical care

The Medicare program was generally billed, for follow-up visits for each day of hospitalization after a Medicare patient's first day in MGH, which was covered by the $40 charge for the initial visit. For the 42 nonsurgical teaching service patients included in our review, the follow-up visits were usually designated as daily visits, and the charges were $10 a day.

Our review of the medical records prepared by physicians (visiting physicians, residents, or interns) showed that, for 117 of the 746 daily visits billed to and allowed by Blue Shield, notations indicating that physicians had seen the patients had not been made by any physician, resident, or intern. Most of the 117 visits were made to five rehabilitation patients. (See p. 18.) For the 629 visits which were supported by physicians' notations, the records for only 11 visits, or less than 2 percent of the daily visits paid for by Blue Shield, contained notations made by the visiting physicians who signed the claims.

The following table summarizes our review of medical records supporting charges for daily visits. For many daily visits, the records showed that more than one physician had seen the patients on the days for which billings were made.

Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Total	Nonsurgical cases: Service rendered on or before July 17, 1969	Nonsurgical cases: Service rendered after July 17, 1969
Occasions of service:			
Billed	746	357	389
Not supported by notations of medical personnel	117	110	7
Supported by notations of medical personnel	629	247	382
Medical personnel identified in the records with the service:			
Visiting physicians:			
Same as identified on bill	11	4	7
Other visiting physicians	16	6	10
Residents	538	209	329
Interns	519	170	349
Medical students	116	45	71
Fellows	52	14	38
Records not signed or signature not identifiable	40	17	23
Total	1,292	465	827

As indicated above, MGH medical records showed no material increase in visiting physicians' involvement in specific services provided to patients after July 17, 1969. In addition, we noted that, regarding charges for daily medical care, the hospital had other problems in complying with SSA's April 1969 guidelines.

Problems in complying with SSA billing requirements regarding continuity of care

In accordance with MGH procedures, the visiting physician on duty at the time of a patient's admission to MGH signs the Medicare claims forms when he completes his monthly tour of duty. The periods of hospitalization of 21 of the 42 nonsurgical patients in our sample continued into another month. Their Medicare claims forms were each signed by a visiting physician who was not on duty during the succeeding month and did not render any services (although the services may have been rendered by the next visiting physician who went on duty).

For example, a patient was hospitalized on October 29, 1968, and was discharged on November 16, 1968. The visiting physician on duty during October signed the Medicare claim form for daily visits at $10 each up to and including November 16, even though his tour of duty ended October 31. In four of the 21 cases, the visiting physicians signed the claims before the patients had been discharged, and in these cases it appeared that charges for daily visits had been added to the claims after they were signed.

In another case, we noted that the patient for whom an initial visit and 26 daily visits had been billed by a visiting physician in the medical service section of MGH had been transferred on the 13th day to the surgical section of MGH where he underwent an operation by a resident. There was no evidence to indicate that the physician in whose name services were billed had visited the patient during any of the time the patient spent in the surgical section of MGH.

In our opinion, the billings for visiting physicians' services in these 21 cases did not comply with SSA's April 1969 guidelines which state that, to be considered an attending physician, the physician must:

> "*** be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization."

In commenting on this point, the director of MGH advised us that, since the regulations did not clearly and explicitly require that the claims forms be personally signed by each physician performing services, he saw no conflict in the fact that continuity of care was provided by two physicians when the stay of a patient continued into the next month and another visiting physician assumed the duties.

We believe that, regardless of which physician signs the Medicare claims form, MGH and its visiting physicians involved in the care of service patients will continue to have problems in complying with the SSA billing requirements concerning continuity of care by an attending physician so long as the physicians' tours of duty are in no way related to the period of a patient's hospitalization.

Other questionable billing practices involving charges for daily medical care

We noted that, after the visiting physicians had described the services rendered on the claims forms and signed the forms, MGH clerical personnel had, in some instances, altered the amount of charges for services. The physicians cognizant of the services advised us that they did not consider such charges to be appropriate.

For example, one visiting physician signed five claims of $40 each for consultations. Without the physician's knowledge, each claim was altered to show a charge of $40 for initial medical care and a charge of $10 for each day the patient was hospitalized, which resulted in a total of $330 being added to the five claims.

Another visiting physician charged Medicare service patients for "long consultations" at $40 each. He viewed the type of service he was rendering as justifying one fee for a long consultation instead of separate fees for initial medical care and daily visits. Without his knowledge, a total of 74 daily visits at $10 each were added to five of his claims.

We brought these cases to the attention of MGH officials who attributed the alterations to clerical errors. They reviewed the claims submitted by the medical service department and found additional alterations for which overpayments had

been received. The overpayments totaling $3,056, including the overpayments which we brought to MGH's attention, were refunded to Blue Shield.

Another problem with MGH's billing procedures related to the lack of documentation to support the claims of the rehabilitation service. Almost all the 117 daily visits (see p. 14) which were not supported by physicians' notations involves five teaching service Medicare patients who had received care in MGH's rehabilitation service. The chief of the rehabilitation service informed us that there was no requirement in his service to include daily progress notes in patients' medical records. He stated that attending physicians, although not necessarily those who signed the claim forms, had visited the patients daily but had not documented many of these visits in the medical records.

MGH reported that, through September 1969, professional fees totaling $3,700 had been received by the Patient Care Improvement Fund for rehabilitation services, of which $3,600 was from Medicare. The claims for these services were all signed during April or May 1969 by the chief of the rehabilitation service although some of the services had been rendered as early as December 1967.

Consultations

MGH's schedule of fees includes a description of two consultation services: (1) "consultation requiring comprehensive diagnostic history and physical examination" with a fee of $40 and (2) "consultation requiring limited history and physical examination" with a fee of $20. Included in the cases we reviewed were nine consultations for which MGH had billed Blue Shield $40 each.

The number and type of medical personnel identified as having been involved in providing consultation services are summarized in the following table. In some cases, more than one person was involved in providing the services. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Consultation services rendered		
	Total	On or before July 17, 1969	After July 17, 1969
Occasions of service:			
Billed	9	2	7
Not supported by notations of medical personnel	1	-	1
Supported by notations of medical personnel	8	2	6
Medical personnel identified in the records with the service:			
Visiting physicians:			
Same as identified on bill	6	-	6
Other visiting physicians	2	2	-
Residents	1	1	-
Interns	1	1	-
Fellows	3	-	3
Total	13	4	9

As shown above, MGH's medical records indicated an increase in the billing physicians' involvement in consultation services after July 17, 1969.

Outpatient services

We reviewed the medical records pertaining to 51 outpatient claims totaling $510, which were billed to and allowed by Blue Shield under part B of Medicare. In 45 cases, the medical records indicated that the physicians who signed the Medicare billing forms had rendered the services. It appears that documentation in the medical records regarding outpatient claims was generally adequate.

Only Medicare was billed for professional fees, in addition to the hospital's clinical charges, for outpatient services. Medicare patients, however, were not billed for deductible or coinsurance amounts.

MGH representatives informed us that other third-party insurers were not billed for outpatient services because the insurers' agreements with subscribers did not cover professional fees for outpatient medical services. Inasmuch as Medicare accounted for only 14 percent of the MGH's outpatient activity and other insurers were not billed for these services, we believe that a question exists whether Blue Shield should pay professional fees under these circumstances, because it cannot be said that the charges are either "customary" or "prevailing."

Operating room surgery

For the 55 Medicare teaching service inpatients in our sample, the MGH billed for 13 surgical operations which required the use of MGH's operating rooms. Of the 13 operations, six were performed before July 17, 1969; the other seven after that date. The charges allowed by Blue Shield for these operations ranged from $100 to $750.

The medical records relating to the six operations performed on or before July 17, 1969, revealed that residents were identified as the principal surgeons; for five of these operations, the attending physicians who signed the Medicare billing forms were listed as assistant surgeons. The attending physician who signed the Medicare billing form for the

sixth operation was not identified in the medical records as either the principal surgeon or the assistant surgeon. This physician informed us that he recalled being present during the operation which was performed on June 2, 1968. Also MGH administrative records supporting this billing showed that the attending physician "supervised but did not scrub" during the operation.

The medical records relating to the seven operations performed after July 17, 1969, showed that residents were identified as the principal surgeons. In three of these seven cases, the attending physicians who signed the Medicare billing forms were identified in the medical records as the principal surgeons.

In summary, the medical records showed that, in all the 13 surgical cases we reviewed, the attending physicians were present during surgery. In one instance, however, the physician did not scrub. The medical records showed that residents were the principal surgeons in 10 cases. Both a resident and an attending physician were designated as principal surgeons in each of the remaining three cases. These statistics may be compared with the statistics on Medicare claims for private surgical patients discussed on pages 29 through 33. According to the medical records for these claims, attending physicians were principal surgeons in all six cases and residents were assistant surgeons in five cases. In the sixth case, the report of surgery did not list an assistant surgeon.

An MGH brochure, entitled "Internship and Residency in General Surgery," appears to support our conclusion, based on the medical records, that the involvement of interns and residents in surgery performed on teaching service patients is different from their involvement in surgery performed on private patients. Excerpts from this brochure follow.

> "During the internship year in general surgery, the intern places his major emphasis on the diagnostic workup of his patients, assistance at their operations and in their postoperative care. He is given major responsibility in each of these areas. He is also early introduced to the operating room as the responsible surgeon. In succeeding years his responsibility steadily increases. Surgical

operative responsibilities are experienced throughout the program and are not reserved for the final year."

* * * * *

"On the private services the house officer [intern or resident] carries major responsibility in the preoperative and postoperative care of patients of the team of staff surgeons with whom he is working. In most cases he functions as first assistant in the operating room in private surgical service cases."

We raise this distinction between service and private patients because SSA's April 1969 guidelines provide that, if the custom in the community is for the attending physician to perform the surgery on private patients, then the attending physician must also perform the surgery on service patients in order to be reimbursed for it.

With regard to being reimbursed for the attending physician's presence in the operating room, the SSA guidelines state that:

"*** if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role."

It appears therefore that the amounts billed for the 10 service patients who were operated on by residents, with attending physicians as assistant surgeons, should have been for duties performed as assistant surgeons and not for the full surgical procedures. According to a widely used relative-value study dealing with physicians' fees and the relative complexity of surgical procedures, the relative value of an assistant at surgery is no more than 20 percent of the value assigned to the surgical procedure.

In commenting on a draft of this report, SSA agreed with our position that reimbursement should have been limited to assistant surgeon duties and advised us that it had asked Blue Shield to obtain additional information on this matter.

MGH officials informed us that the medical records pertaining to these 10 operations were inaccurate. We were informed that, in all cases in which attending physicians had signed Medicare surgery claims, the physicians had met the criteria for reimbursement as attending physicians in a teaching setting. MGH officials also stated that Medicare had been billed for general surgical procedures only if the attending physician was present in the operating room and participated in the preoperative and postoperative care of the patient.

The chief of the general surgical service stated that it had been common practice to list the resident as the principal surgeon in the teaching service sector of the hospital if he participated in the operation under the supervision of an attending physician responsible for the operation. In some instances, he added, the attending physician may have performed the more critical phase of the operation, although the medical records did not indicate that fact.

The surgical services chief told us, however, that, in the private sector of the hospital, it was customary to list attending physicians as principal surgeons when they were present and responsible, regardless of their involvement in the operations.

MGH officials recognized that the medical records had not adequately supported their Medicare claims for surgery. They advised us that, in the future, the medical records for service patients would show the attending physician as the principal surgeon when he believes that his services meet the criteria for reimbursement as an attending physician, which, we believe, may result in merely a record change with no change in the extent of the attending physician's participation in the surgery.

MGH and Blue Shield comments

In regard to the lack of documentation relating to the services billed for 42 nonsurgical Medicare service patients, MGH officials stated that the medical records were not accounting records and did not adequately reflect the number of times attending physicians visited the patients. They stated also that, in the future, Medicare would be billed for initial medical care, daily visits, and consultation services furnished

to its patients only when adequate documentation appears in MGH's medical records supporting each individual charge. MGH has devised a form to be completed whenever an attending physician visits a patient.

In commenting on a draft of this report, the director of MGH stated that the lack of notations in the medical records did not mean that the services were not performed. He stated that it was difficult to see how we could report our observation that the visiting physician, whom we accompanied on his medical rounds (see p. 5), did not write into the medical records and then use the absence of such entries to imply that the services were not performed by attending physicians.

We accompanied one visiting physician on his medical rounds to gain some insight into his relationship to the interns and residents and to the patients. Although we noted that this physician did not write into the medical records, we could not, on the basis of this limited tour, conclude that attending physicians never write into the medical records, particularly in view of the notations in medical records of private patients. (See pp. 29 to 33.)

In commenting on the reimbursement for a full surgical fee where a resident was listed as the principal surgeon, the director advised us that our observations were in contradiction to the Code of Federal Regulations (20 CFR 405.521(b)) which states that, in the case of major and other complex and dangerous procedures or situations, the personal and identifiable direction of the attending physician must include supervision by him. The director stated that the code does not state that the surgeon must actually perform the surgery in order to claim reimbursement for full surgical procedures.

The code states also that a charge should be recognized under part B of the Medicare program only if the attending physician's services to the patient are of the same character, in terms of responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. As discussed previously in this report, our review of the medical records of MGH showed that, for operations on private patients, the attending physicians had been shown as the principal surgeons, whereas for operations on teaching service patients, the attending physicians generally had been shown as the assistant surgeons.

Blue Shield officials stated that, in a recent review of MGH's medical records, they had found that documentation of medical services was the same as we had described. Their review, which was undertaken in February 1970, revealed that, in cases of daily medical care, the notations by visiting physicians consisted, at best, of one note only. Blue Shield also found that surgery notes showed performance of surgical procedures by residents with attending physicians as assistant surgeons.

PATIENT INVOLVEMENT

The comptroller of MGH informed us that Medicare patients were not billed for the $50-deductible and 20-percent-coinsurance amounts when services had been rendered in the teaching service sector of MGH for either inpatients or outpatients. This was in accordance with MGH's policy of not charging teaching service patients professional fees because they did not have sufficient financial resources.

The patients were responsible for $3,102 of the $14,345 allowed by Blue Shield for the 55 inpatient and 51 outpatient claims included in our sample, because of deductible and coinsurance amounts. MGH, however, did not bill the patients for these amounts.

MGH officials advised us that, if they were physically able, service patients signed the appropriate Medicare claims forms at the time of admission. Of the 55 claims submitted in behalf of teaching service inpatients, only nine had been signed by the patients and 13 had been signed by patients' relatives; the remaining 33 claims had been signed by hospital employees.

We were informed by Blue Shield officials that appropriate notifications (Explanations of Benefits forms) were always sent to Medicare patients when claims were processed on their behalf.

DETERMINATION OF REASONABLE CHARGES AND AMOUNTS ALLOWED

Payments for physicians' services under part B of the Medicare program are made on the basis of reasonable charges. The Medicare law requires that, in determining reasonable charges, consideration be given to the customary charge of the physician performing the service and to the prevailing charge in the locality. SSA regulations provide that the maximum allowable charge be the customary charge or the prevailing charge, whichever is lower.

We found that Blue Shield did not follow SSA instructions concerning the evaluation of the reasonableness of the uniform schedule of charges adopted by supervisory and teaching

physicians. SSA's April 1969 guidelines outline the method to be followed by the insurance organizations (carriers) that make Medicare part B payments in complying with the reasonable charge criteria for charges made by groups of physicians, such as members of the Patient Care Improvement Fund, as follows:

> "Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved."

Blue Shield officials advised us that they had not complied with the above instructions because it was not feasible or practical to do so. Blue Shield stated that:

> "The customary charge profiles that were developed for the *** [Patient Care Improvement Fund] were developed from data based on its own charges. It would not be feasible with Medicare or regular business to attempt to meld prior charge data of each physician who becomes a participant in this and other physician association groups to develop customary charge profiles. There are also added factors that would not make this melding practical since the private practice charges of a physician would invariably differ because of circumstances, i.e., expenses, geographic location, etc., from those charges made as a participant in the *** group."

The principal reduction in the charges allowed by Blue Shield was for initial medical care which generally was reduced from $40 to $25. Some small reductions were also made for surgical procedures.

In our opinion, Blue Shield, to comply with SSA's April 1969 guidelines regarding payments for services of supervisory

and teaching physicians, should have compared the charges on the uniform fee schedule used by MGH with the average reasonable charges which would have been determined if each physician were individually reimbursed for the services involved. The uniform fee schedule should then have been reduced for those procedures for which the average reasonable charges were less than the amounts that were proposed in the fee schedule. SSA advised us that it was pointed out to Blue Shield again in May 1970 that the appropriateness of MGH's fee schedule needed to be established.

In commenting on a draft of this report, the director of MGH stated that the fairest and most economical way to administer the system of charging fees for daily visits was to charge one daily-visit fee for each day a patient was hospitalized, regardless of the number of times the patient was seen in any one day or whether the patient was seen at all on a particular day.

He stated that the uniform fee schedule, which limited the fees a physician could charge "people of moderate means," initially had been established in the Baker Memorial Hospital division of the MGH in 1930 and had been carried over into the operation of the Patient Care Improvement Fund. He stated also that this practice was in accordance with the Code of Federal Regulations which provides that the amounts payable for services of physicians supervising interns and residents be determined in accordance with the criteria for determining reimbursements for services which the physicians render to private patients.

As discussed on pages 7 and 8, although the physicians performed similar services for both Medicare and non-Medicare patients, the non-Medicare teaching service patients were not charged for professional services (except for surgical procedures and related care). In our opinion, this factor should be considered by Blue Shield in determining the physicians' customary charges.

COMPARISON OF MEDICAL RECORDS
OF PRIVATE PATIENTS WITH
TEACHING SERVICE PATIENTS

To compare the information shown in the medical records of teaching service patients with that shown in the medical records of private patients, we reviewed the medical records of 12 Medicare private patients who were hospitalized in the Phillips House unit and in the Baker Memorial Hospital of MGH after July 17, 1969.

We found that the private patients' medical records contained documentation supporting that their attending physicians had personally rendered the services for which these physicians had billed the Medicare program. This differed from the situation in the teaching service sector of MGH where, as previously noted, very little documentation existed to show that visiting physicians had been involved in providing the specific services for which the Medicare program had been billed.

The rules of the MGH board of trustees also distinguished between private patients and teaching service patients in describing the role of the responsible physician. The rules of the trustees stated that:

> "The recorded final diagnosis in the medical record of each discharged Service patient shall be signed by the responsible resident of the appropriate Service under the supervision of the Chief of that Service.
>
> "For private patients it shall be the responsibility of the attending physician to sign the final diagnosis himself."

Of the 12 private Medicare cases reviewed by us, six were nonsurgical and six were surgical. The nature and number of services involved, as well as the amounts billed to and allowed by Blue Shield, are summarized in the following table.

Private Patient Billings

	Occasions of service	Amounts billed by physicians (note a)	Amounts allowed by Blue Shield (note a)
Medical services:			
Initial medical care	6	$ 80	$ 80
Daily visits	66	775	400
Consultations	4	120	120
Total medical services	76	975	600
Surgical services requiring use of operating room	6	3,150	2,720
Total	82	$4,125	3,320
Less deductibles and coinsurance payable by beneficiaries			756
Total payments reviewed			$2,564

[a]The total amounts billed and the total amounts allowed for initial medical care and daily visits did not include amounts relating to two initial visits and 23 daily visits for which claims had not been received by Blue Shield at the time of our review.

The number and type of medical personnel identified as having been involved in providing medical care to the six non-surgical private patients are summarized in the following table.

Charges For Medical Services

	Initial medical care	Daily visits	Consultations
Occassions of service billed	6	66	4
Medical personnel identified in the records with the service:			
Attending physicians:			
Same as identified on bill	6	39	4
Other attending physicians	-	16	-
Residents	1	21	-
Interns	2	18	-
Medical students	3	9	-
Fellows	-	3	2
Records not signed or signature not identifiable	-	5	-
Total	12	111	6

The differences, as shown by the records, between the involvement of the private attending physicians in the services billed Medicare for their patients and the services billed Medicare for teaching service patients are discussed in the following subsections.

Initial medical care

We found that, in all six nonsurgical private cases, the records indicated that the physicians who had signed the bills had rendered initial medical care on the first day of hospitalization. In contrast, in one half of the teaching service cases reviewed, the medical records did not contain any evidence that visiting physicians had rendered initial medical care.

Daily medical care

Medical records of these six private nonsurgical cases contained notations made by the patients' private physicians on 39 of the 66 days for which daily visits were billed

(about 59 percent of the time). Further, the medical records indicated that attending physicians, other than the patients' private physicians, had visited the six patients 16 times during the 66 days.

In contrast, there was documentation in the medical records showing, for teaching service patients in our sample, the involvement of billing physicians in only 11 of the 746 daily visits (less than 2 percent) for which the services of visiting physicians had been billed by the hospital. The medical records also indicated that visiting physicians, other than those who had signed the billing forms, had visited the patients on 16 of the 746 visits.

Consultations

Four consultation charges were included in the six nonsurgical private cases we reviewed. In all four instances, the records showed that the private physicians who had submitted the bills had been involved in rendering the services.

In nine cases, consultations for teaching service patients were billed by the hospital. Records indicated, however, that in only six cases had the visiting physicians who signed the bills been involved in rendering the services.

Surgical procedures performed in operating rooms

Medical records concerning six operations on private patients showed that attending physicians were the principal surgeons in every case. In five of the six cases, the physicians were assisted by residents. In contrast, in only three of the 13 surgical claims for teaching service patients was there evidence that the attending physicians had been the principal surgeons.

MGH and Blue Shield comments

We pointed out to MGH and Blue Shield officials the differences in the amount of documentation relating to physicians' involvement between the private cases and the teaching service cases.

MGH officials did not comment on these differences. In commenting on a draft of this report, however, the director of MGH advised us that the implication that the responsible resident of the appropriate service was the responsible physician for service patients was not true and that the statement issued by MGH on October 30, 1967 (see p. 6), recognized that the responsibility for medical care rendered to service patients was vested in the assigned visiting physician.

Blue Shield officials advised us that in their review they also had found that physicians' notations in private patient records were much more detailed than were visiting physicians' notations in teaching service patient records.

OTHER MEDICAL INSURANCE PROGRAMS AND INDIVIDUALS PAYING FOR VISITING PHYSICIANS' SERVICES

It was the practice of MGH to not bill teaching service patients who did not have medical insurance for professional fees of visiting physicians.

In commenting on a draft of this report, the MGH director stated that MGH had had an official policy from December 4, 1959, when voted by the hospital trustees, of charging professional fees for teaching service patients. At that time, it was expressly stipulated by MGH's trustees that this action did not alter the policy of MGH that all persons were welcome in MGH, regardless of their ability to pay, and that charges were to be adjusted in accordance with that ability. The director stated that it had quickly developed that only those with third-party insurance could afford such charges and that the cost of identifying, charging, and collecting from the uninsured patients was prohibitive.

We were also informed by the MGH comptroller that it was MGH's policy to bill all third-party insurers that would pay for the services of visiting physicians whenever, in the judgment of the individual physician, a service which warranted a professional fee had been rendered.

We found that, in practice, only Medicare patients who had part B coverage were billed professional fees for inpatient services; with the exception of surgical procedures

and related care, third-party insurers, other than Medicare, were not charged for comparable services.

From its inception through September 30, 1969, the Patient Care Improvement Fund received about $189,000 under part B of Medicare and minor amounts from the State Medicaid program[1] and the Medex plan (Blue Cross-Blue Shield complementary coverage) for professional services rendered to medical service inpatients and to clinical outpatients. No funds were received from other insurers or patients for comparable services.

Hospital representatives informed us that generally third-party insurers, other than Medicare, were not billed because non-Medicare insurance policies did not provide for honoring claims for hospital medical care for teaching service patients or for outpatient medical services. The MGH comptroller informed us that the hospital intended to continue its attempts to obtain more monies from third-party insurers other than Medicare. The comptroller stated that, in his opinion, Blue Shield should honor claims for professional services rendered to teaching service patients under its medical insurance policies.

He stated also that MGH planned to begin billing the State Medicaid program in the near future for professional services rendered to all recipients whenever the visiting physician believed that the service rendered by him met the criteria for reimbursement.

For surgical cases, we found that Blue Shield honored claims under its medical insurance policies whenever the attending physician had been in the operating room and had

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[1]The amounts received were minor and represented only the deductible and coinsurance amounts for those Medicare patients who were also eligible for Medicaid. MGH did not receive professional fees under the Medicaid program except for those Medicare patients who had this complementary coverage.

scrubbed to assist in surgery. Through September 30, 1969, the Patient Care Improvement Fund received about $140,000 from Medicare and about $110,000 from third-party insurers for surgery and related services. This $110,000 included about $85,000 from Blue Shield and $20,000 from other insurers, such as Aetna Life Insurance Company, Metropolitan Life Insurance Company, and John Hancock Mutual Life Insurance Company. About $5,000 was received under the Medex plan and under the Medicaid program for those Medicare patients who had this complementary coverage.

Policy of Blue Shield

Except for surgically related procedures, Blue Shield did not honor claims for inpatient medical services furnished to its subscribers who were teaching service patients at MGH. Blue Shield also did not pay professional fees for outpatient services.

We were informed by a Blue Shield official that one of the benefit conditions of its medical insurance policies was that professional fees be paid only for services rendered to private patients. A "private patient" was defined by Blue Shield policies as a patient with whom a physician or dentist has an express or implied contract to render services for a fee. Since service patients were not expected by MGH to pay for medical services if they had no insurance, Blue Shield considered that no contract, express or implied, existed between its subscribers who were service patients and the visiting physicians on MGH's teaching service.

Blue Shield did honor claims for surgically related procedures performed on its subscribers if the attending physicians were in the operating room and had scrubbed for surgery. Blue Shield officials could not explain the apparent inconsistencies in its policy, except to point out that the tradition of paying for surgery performed by interns and residents might stem from a recognition that it was necessary for these doctors to obtain surgical experience.

SUSPENSION AND RESUMPTION OF PAYMENTS FOR SERVICES OF VISITING PHYSICIANS

Blue Shield reported that on May 1, 1969, it received SSA's April 1969 guidelines which were intended to clarify and supplement the criteria that govern reimbursement for the services of supervisory and teaching physicians.

On June 27, 1969, Blue Shield mailed the guidelines to the 58 hospitals in Massachusetts affiliated with medical schools, including MGH. On July 17, 1969, MGH distributed the guidelines to each chief of service. Blue Shield officials informed us that they suspended all part B payments to the 58 teaching hospitals on August 11, 1969, pending an audit of claims at each of the hospitals to determine whether such payments were proper. An audit was made by Blue Shield at MGH on October 6, 1969.

We were advised by the Blue Shield officials who made the audit that they had not retained any workpapers and could not identify the Medicare patients whose medical records had been examined. The Blue Shield report on the results of the audit concluded that "the recordation at the hospital is fantastic" and "on each medical record there is complete documentation for all services rendered."

Blue Shield, apparently satisfied that visiting physicians at MGH were performing the services for which claims were being submitted under part B, resumed payments on October 10, 1969. According to Blue Shield officials, the audit consisted of examining patients' medical records relating to 100 "live" Medicare claims (current claims as they came in for payment).

The Blue Shield officials responsible for the audit told us that, at the time of the audit, they were not familiar with the organization of MGH (i.e., private sector and teaching service sector). Accordingly, in their selection of claims, particular attention had not been given to selecting claims from that sector of the hospital where the visiting physicians were performing supervisory and teaching duties.

Also these officials told us that they had examined mostly surgically related claims and did not recall examining

any nonsurgical claims. It appears to us that Blue Shield, in its audit of 100 selected live claims, may not have examined claims involving patients who were hospitalized in the teaching service sector of the hospital but examined only claims relating to private patients. This appears to be the most likely explanation of why the results of its initial audit differed significantly from ours.

About midpoint in our audit, we met with Blue Shield officials to advise them of the results of our audit to date (examination of 32 medical records), which were essentially the same as discussed in this report. We also pointed out that, by selecting claims submitted by visiting physicians who assigned their professional fees to MGH's Patient Care Improvement Fund, we had selected cases in which the services had been rendered to teaching service patients. Blue Shield officials advised us that, in future audits, they would use the same approach. In February 1970 Blue Shield made another audit at MGH and found essentially the same type of problems as we did in our review.

To further clarify the nature of documentation required for supervisory and teaching physicians to comply with SSA's April 1969 guidelines, on March 25, 1970, Blue Shield sent letters to the 58 Massachusetts teaching hospitals in which Blue Shield presented additional instructions for billing Medicare. Thus, about 1 year after the issuance of SSA's guidelines, Blue Shield issued its implementing instructions. In general, the Blue Shield instructions indicated that visiting physicians could submit part B billings only for those services that were substantiated by hospital medical records. The instructions stated that the records should include the teaching physician's personal notes and his signature or his countersignature on the resident's or intern's notes for each visit for which he submitted a billing to Medicare, provided that these services were rendered under his direct supervision.

Blue Shield stated that the above instructions were to be effective April 1, 1970. The instructions were silent regarding those claims that were submitted prior to April 1, 1970. Blue Shield officials advised us that they had not yet decided upon the propriety of past payments made to teaching physicians at the 58 teaching hospitals in Massachusetts.

Both Blue Shield and SSA officials told us that another audit of medical records supporting past claims would be made to determine the propriety of payments made to the Patient Care Improvement Fund prior to April 1, 1970. SSA also advised us that on May 19, 1970, it had recommended to Blue Shield that further payments to MGH be suspended until the carrier could establish that reimbursements were for covered services and at the proper rates. On July 15, 1970, Blue Shield again resumed payments for professional fees for surgical procedures and for outpatient visits but not for inpatient medical services.

In commenting on a draft of this report, the MGH director stated:

> "The MGH will of course comply with the intent of the Law, but it is our sincere belief that we have complied with the Federal Code. The exceptions taken by the GAO are based upon intermediary letters which have not been filed in the Federal Register and only represent a suggested interpretation of the Federal Code. The MGH received a copy of the principal letter in question *** [SSA's April 1969 guidelines] in July, 1969. The final implementing letter from our Part B Carriers was dated March 25, 1970, and received in early April, 1970.
>
> "It is incomprehensible and indeed reprehensible that interpretative guidelines issued long after the fact could be applied retroactively or indeed applied at all when they do not conform to the Federal Code and have not been filed in the Federal Register."
>
> * * * * *
>
> "*** We would further suggest that any future interpretations of the law be filed in the Federal Register on a prospective basis in order that the financial stability of the teaching hospital be maintained."

Although MGH implied that SSA's April 1969 guidelines changed the basic ground rules regarding payments to

supervisory and teaching physicians, SSA has stated that these guidelines were merely intended to clarify and supplement the criteria for making such payments.

SSA's April 1969 guidelines were issued to the insurance organizations, such as Blue Shield, to clarify the situations under which they could properly make Medicare payments for the services of supervisory and teaching physicians. The guidelines were furnished by Blue Shield to MGH so that MGH would have the opportunity to observe the criteria under which such payments could be made.

The underlying purpose of the Federal Register Act (44 U.S.C. 1501) is to afford a basis for giving constructive notice of Government regulations. Where the regulations or guidelines of April 1969 were, in fact, placed in the hands of the persons or institutions regulated as was the case at MGH, such persons or institutions would be chargeable with knowledge of such regulations or guidelines from the time they received them and publication in the Federal Register would not be required.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

May 7, 1970

The Honorable
Elmer B. Staats
Comptroller General
of the United States
Washington, D. C.

Dear Mr. Staats:

I understand that your office has been making reviews of Medicare payments for the services of supervisory and teaching physicians at five hospitals which are similar to the review made at the request of this Committee of Medicare payments to supervisory and teaching physicians at Cook County Hospital in Chicago, Illinois. I also understand that your Office contemplates issuing an overall report to the Congress presenting the findings, conclusions, and recommendations developed in connection with the reviews at the five hospitals.

On May 4, 1970, the Committee on Ways and Means of the House of Representatives announced that, in connection with its consideration of amendments to title XVIII of the Social Security Act, it had proposed certain restrictions with respect to payments under the supplementary medical insurance (part B) portion of the Medicare program to supervisory and teaching physicians.

This Committee will soon consider legislative changes concerning Medicare payments to supervisory and teaching physicians. In connection with this work, would you please furnish to this Committee individual reports of these reviews.

Although it will not be necessary for you to develop overall conclusions and recommendations relating to this information, the material furnished to this Committee should at least cover the following points with respect to the payments made on behalf of selected Medicare beneficiaries:

1. The extent that the services paid for were furnished by the supervisory or teaching physician in whose name the services were billed, by other attending physicians, or by residents and interns, as shown by the hospitals' medical records. Also, information as to any changes in billing or record-keeping practices since the implementation of Social Security's April 1969 guidelines relating to such payments.

2. The extent to which payments made from Medicare (part B) funds represented payments for services of physicians whose compensation may have also been reimbursed in part to the hospitals under the hospital insurance (part A) portion of Medicare. For those physicians who were not compensated by the hospitals, information as to their medical school affiliations and the bases for their compensation by these institutions would be helpful.

3. Information as to whether the individual physicians bill for claimed services or whether the billing is done by the hospital or some other organization, and information as to the disposition of such funds obtained from part B of the Medicare program. For example, are the payments retained by the physician or are they turned over to the hospital, medical school, or some other organization.

4. Whether: (a) the Medicare patients were billed for and subsequently paid the deductible and coinsurance portions of the Medicare charges, (b) the patients signed the appropriate claims forms requesting that Medicare payments be made on their behalf, and (c) the patients received "explanations of benefits" or other notification of the payments made on their behalf.

5. Information as to the basis for arriving at the amounts of "reasonable charges" for the services paid for.

6. Information as to whether any other medical insurance programs or other patients regularly made payments for services provided by the supervisory and teaching physicians at the hospitals in amounts comparable to those paid from Medicare funds under comparable circumstances.

7. Information as to the steps taken by the hospitals and the carriers to obtain compliance with SSA's April 1969 guidelines concerning payments to supervisory and teaching physicians, including actions taken to suspend or recover payments.

8. Any other pertinent information which you believe would be helpful to this Committee in its consideration of the subject.

Although there is no need to obtain formal advance comments from the Department of Health, Education and Welfare, the Committee has no objection to your Office discussing the matters covered in the reports with appropriate officials of the Department.

With every good wish, I am

Sincerely,

Chairman

B-164031(4)
9-30-70

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

(11)

B-164031(4)

Massachusetts Medical Service (Blue Shield)
Massachusetts General Hospital,
Boston

SEP 30 1970

Dear Mr. Chairman:
Wilbur D. Mills

On August 21, 1970, we submitted a report to you on our review of payments made by the Michigan Medical Service under part B of the Medicare program for the services of salaried supervisory and teaching physicians at Herman Kiefer Hospital in Detroit, Michigan. The report was furnished to you at the request of Mr. William Fullerton of the staff of the Ways and Means Committee. That report was the first of five such reports requested by the Chairman of the Senate Committee on Finance.

This report (enc. I) deals with our review of Medicare part B payments made by the Massachusetts Medical Service (Blue Shield) for the services of supervisory and teaching physicians at the Massachusetts General Hospital in Boston, Massachusetts. It is the second report submitted in accordance with Mr. Fullerton's request.

The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various private insurance companies, such as Blue Shield organizations, for making benefit payments for physicians' services under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program.

Following is a summary of the information obtained during our review at the Massachusetts General Hospital. These points are discussed in more detail in the enclosure.

--During the period October 30, 1967, through September 30, 1969, Blue Shield paid about $296,000 to the hospital under part B of the Medicare program for the services of supervisory and teaching physicians who were affiliated principally with the Harvard Medical School. The billings by the hospital were on a fee-for-service basis in the names of specific physicians for specific services provided to specific Medicare patients who were inpatients in the teaching service section of the hospital. (See pp. 2 to 9.)

--Our review of the hospital medical records applicable to selected Medicare patients who were treated in the teaching service section of the hospital and in the private patient sections of the hospital showed wide differences in the involvement of the physicians in whose names the claims were submitted in the specific services for which part B payments were made. SSA regulations state that, under part B of the Medicare program, a charge should be recognized for the services of an attending physician who involves residents and interns in the care of his patients only if his services to the patient are of the same character as the services he renders to his other paying patients.

Our examination of medical records of selected Medicare patients in the teaching service section of the hospital indicated that, for nonsurgical cases, the services paid for by Blue Shield were usually provided by residents and interns, rather than by the physicians in whose names the claims were submitted. For example, of the 746 charges for daily visits included in the payments we reviewed, the medical records showed that the physician in whose name the claims were submitted was involved in providing services on only 11 occasions, or less than 2 percent of the daily visits billed.

Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but their salaries were reimbursed to the hospital under the Hospital Insurance Benefits for the Aged (part A) portion of the Medicare program, which meant, in effect, that the program could be paying twice for the same service. (See pp. 10 to 15.)

For surgical cases involving Medicare teaching service patients, the physician in whose name the claims were submitted was present in the operating room for every case reviewed but medical records showed that, in most cases, a surgical resident had been designated as the principal surgeon. (See pp. 20 to 23.)

In contrast, our comparison of medical records of selected Medicare private patients with the hospital's medical records showed that, for the daily visits billed, the billing physician had made notations in the medical records for about 59 percent of the daily visits billed. Also, for the surgical cases reviewed that involved private patients, the billing physician was shown in the medical records as the principal surgeon in every instance. (See pp. 29 to 33.)

--In addition to indicating the lack of evidence of the involvement of the supervisory and teaching physicians in the specific services billed in their names, our review indicated that the hospital had other problems in complying with SSA guidelines outlining the circumstances under which payments for services rendered by supervisory and teaching physicians could be made.

1. According to the SSA guidelines, in order for the hospital to bill, the teaching physician must:

"*** be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care at least throughout the period of hospitalization."

At Massachusetts General Hospital, the assignments of supervisory and teaching physicians to the teaching service section of the hospital were not related to the period of the patients' hospitalization. Accordingly, services were billed in the names of supervisory and teaching physicians for periods during which the physicians were no longer assigned to the care of the patients. (See pp. 16 and 17.)

2. For claims for physicians' services rendered in one section of the hospital, there was a lack of evidence that the services had been provided. (See p. 18.)

--The funds collected by the Massachusetts General Hospital under Medicare for the treatment of teaching service patients were deposited into the Patient Care Improvement Fund administered by the hospital. About 55 percent of the funds collected through September 30, 1969, had been expended for specific purposes, such as salary supplements for the supervisory and teaching physicians. The remaining 45 percent had been transferred to the general funds of the hospital. (See pp. 7 to 9.)

--Generally the Medicare teaching service patients were not billed by the hospital for the coinsurance and deductible amounts. Also, of the 55 claims reviewed by us that had been submitted on behalf of teaching service patients, only nine had been signed by the patients, 13 by the patients' relatives, and 33 by hospital employees. Blue Shield, however, did notify the patients of the payments made on their behalf. (See p. 26.)

--The basis for the hospital's charges to part B of the Medicare program on behalf of the teaching service patients was a uniform fee schedule initially developed by the hospital for private patients of moderate means. In our opinion, Blue Shield did not follow SSA instructions concerning the evaluation of the reasonableness of the fee schedule because there was no assurance that fees did not, in the aggregate, exceed the amounts that would have been charged if the physicians had billed separately. (See pp. 26 to 28.)

--Except for surgical procedures and related care, only Medicare was billed professional fees for inpatient and outpatient medical services in the teaching service section of the hospital. Third-party insurers, other than Medicare, were not charged for comparable services. Blue Shield did honor claims for surgery under its medical insurance policies in certain circumstances. (See pp. 33 to 35.)

--SSA, Blue Shield, and the hospital have been slow in complying with SSA's April 1969 guidelines which set forth the circumstances under which Medicare payments to supervisory and

teaching physicians could be made. In June 1969, Blue Shield furnished these guidelines to the 58 teaching hospitals in the State of Massachusetts. In August 1969, Blue Shield suspended part B payments to these hospitals, including Massachusetts General Hospital, pending an audit of the claims at each hospital. Blue Shield's initial audit at Massachusetts General Hospital was made in October 1969. On the basis of this audit, Blue Shield concluded that the supervisory and teaching physicians at the hospital were performing the services for which claims were being submitted under part B and resumed payments to the hospital.

Blue Shield, however, did not retain any working papers and did not know the names of the Medicare patients whose medical records had been examined. Because the results of Blue Shield's October 1969 audit differed substantially from the results of our review, we made inquiries of Blue Shield officials and learned that it was likely that Blue Shield had examined mostly surgical cases or claims for services to private patients. Subsequently, Blue Shield made another audit at the hospital involving claims for services to patients in the teaching service section of the hospital and found essentially the same type of problems as we did in our review.

In March 1970, or about a year after the issuance of SSA's guidelines, Blue Shield issued its implementing instructions to the teaching hospitals in Massachusetts to further clarify the conditions which must be met for supervisory or teaching physicians to be paid for professional services to individual patients under part B of the Medicare program.

SSA advised us that in May 1970 it had recommended to Blue Shield that further payments to the hospital be suspended until Blue Shield could establish that reimbursements were for covered services and at the proper rates. SSA and Blue Shield also stated that another audit of prior payments to the hospital was being made to establish the extent of any possible overpayments.

Comments pertinent but limited

On July 15, 1970, Blue Shield again resumed making payments for surgical cases and for outpatient clinical visits but not for inpatient medical services.

In commenting on a draft of this report, the hospital pointed out that, inasmuch as SSA's April 1969 guidelines had not been published in the Federal Register, they could not be considered regulations.

The underlying purpose of the Federal Register Act (44 U.S.C. 1501) is to afford a basis for giving constructive notice of Government regulations. The SSA guidelines were received by the Massachusetts General Hospital by July 1969, and the hospital therefore would be chargeable with knowledge of such guidelines in the same manner as if they had been published in the Federal Register. (See pp. 36 to 39.)

On May 21, 1970, the House of Representatives passed House Bill 17550, entitled "Social Security Amendments of 1970." One of the provisions of the bill would change the basis of reimbursement for supervisory and teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis when the physicians' services are furnished in a setting containing either of the following circumstances.

1. The non-Medicare patients, even when able to pay, are not obligated to pay the billed charges for physicians' services.

2. Some or all of the Medicare patients do not pay the deductible and coinsurance amounts related to the physicians' charges.

We believe that this report will be of interest to your Committee because it is concerned with one example of the variety of teaching arrangements mentioned in the report of your Committee on House Bill 17550 and discusses some of the difficulties mentioned in that report in achieving effective and uniform application of existing SSA policies involving reimbursement on a fee-for-service basis to a large number of hospitals operating under widely varying teaching arrangements.

The Committee report pointed out that there are teaching hospitals in which teaching physicians are responsible both for private patients whom they have admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned to the physicians for care by the hospital.

The enclosed report on Medicare payments for services rendered by supervisory and teaching physicians in the Massachusetts General Hospital shows that, according to the hospital's medical records, there were differences in the extent of personal involvement of attending physicians in the care of their private patients and in the care of their teaching service patients. Also, with respect to the payments we reviewed, these differences had not been taken into consideration in determining the basis for and amounts of reimbursement made under the Medicare program.

The matters discussed in the report were presented to SSA, Blue Shield, and the hospital for review. Their written comments were considered by us in the preparation of this report.

We trust that the information contained in this report will be of assistance to your Committee.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

Enclosure

The Honorable Wilbur D. Mills
Chairman, Committee on Ways and Means
House of Representatives

GENERAL ACCOUNTING OFFICE

EXAMINATION INTO

MEDICARE PAYMENTS FOR SERVICES OF

SUPERVISORY AND TEACHING PHYSICIANS AT

THE MASSACHUSETTS GENERAL HOSPITAL

BOSTON, MASSACHUSETTS

INTRODUCTION

The Medicare health insurance program was established under title XVIII of the Social Security Act (42 U.S.C. 1395), effective July 1, 1966. The Medicare program is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare, which has entered into contracts with various insurance companies, such as Blue Cross and Blue Shield organizations, for making benefit payments under the program.

Medicare provides two forms of health protection for eligible beneficiaries aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, as well as posthospital care in an extended-care facility or in the patient's home. Payments for this protection are made from a trust fund financed through a social security payroll tax. Blue Cross is the principal organization in Massachusetts making benefit payments under part A.

The second form, designated as Supplementary Medical Insurance Benefits for the Aged (part B), covers physicians' services. Part B benefits are paid from a trust fund financed through premiums paid by beneficiaries electing to participate and matching contributions from funds appropriated by the Federal Government. Effective April 1, 1968, the monthly premium was increased from $3 to $4; effective July 1, 1970, the premium was increased to $5.30. The beneficiary is responsible for paying the first $50 (deductible) for covered services in each year and 20 percent of the

reasonable charges in excess of the first $50 (coinsurance). Massachusetts Medical Service (Blue Shield) is the principal organization making part B benefit payments in Massachusetts.

Payments to supervisory and teaching physicians

Payments to supervisory and teaching (visiting) physicians at teaching hospitals are allowed by SSA regulations under part B. SSA regulations issued on August 31, 1967, stated that to qualify, the physician must be the Medicare patient's attending physician and either render services personally or provide "personal and identifiable direction to residents and interns" participating in the care of his patient. The salary costs of hospital residents and interns under an approved training program are reimbursed to the hospital under part A. In April 1969, SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payments for services of supervisory and teaching physicians.

MEDICAL CARE AT THE MASSACHUSETTS GENERAL HOSPITAL

The Massachusetts General Hospital (MGH) is a privately incorporated teaching hospital that receives funds for patient care from patients and from third-party insurers, both governmental and commercial. The hospital receives funds also through Government research grants and private contributions and endowments.

MGH consists of three main divisions: Phillips House, a unit for private patients of physicians on the MGH staff; Baker Memorial Hospital which has both private and semiprivate accommodations for private patients of moderate means; and the general hospital wards which are for the care of service patients generally classified as those patients who are unable to pay the MGH charges and professional fees of other units of MGH. The service patients have been MGH's principal source of patients used in teaching programs for residents and interns.

MGH has about 1,070 beds, of which 582 are for private patients and 488 are for teaching service patients. There

are instances in which private patients may be housed in the service sector of MGH and teaching service patients may be housed in the private sector. This would be the case when either the private sector or the service sector could not accommodate patients normally housed in its area.

Our review of MGH records indicated that medical care in the private sector of MGH was primarily the responsibility of staff physicians with some assistance from residents and interns. The records indicated that, in the service sector, the staff of residents and interns rendered most of the medical care, with overall supervision provided by a staff of supervisory and teaching physicians.

For the fiscal year ended September 30, 1969, the hospital reported 355,921 inpatient days, of which 100,112, or 28 percent, were for Medicare patients. The inpatient costs for the year were about $36.6 million, of which about $10.6 million, or 29 percent, applied to Medicare patients. The outpatient costs for the same period amounted to about $7.4 million, of which about $1 million, or 14 percent, applied to Medicare patients.

MGH provides a wide range of services, such as surgery, gynecology, pediatrics, and medical services, and operates about 70 general and specialty clinics. In November 1969, the hospital reported that the staff included 787 staff physicians, 300 residents and interns, and 300 clinical and research fellows.

Affiliation with
Harvard Medical School

MGH and six other hospitals in Boston are affiliated with the Harvard Medical School. Under this affiliation, the hospitals have the primary responsibility for the care of patients and for the prevention and treatment of disease. Efforts are made, however, to ensure that a large proportion of the school's faculty members are associated with one or more of the affiliated hospitals and that a large proportion of those physicians holding the more responsible positions in the hospitals are active members of the school's faculty.

According to the associate dean of the school, about 75 percent of the staff physicians of MGH are on the school's faculty.

Compensation of physicians

Physicians, other than residents and interns who are salaried employees of MGH, have various arrangements with MGH for their compensation. Generally those involved in internal medicine bill their private patients direct for services rendered in the hospital. Surgeons bill their private patients and either retain the monies received or, if they are members of the MGH Surgical Associates, remit the monies to MGH which administers a fund for the member surgeons.

All MGH staff radiologists are members of Radiological Associates, and billings for radiology services are made by the association. The association turns over all monies received for professional services to the hospital which pays the radiologists' salaries. Hospital officials estimated that about 10 percent of the monies generated by Radiological Associates each year is donated to MGH.

In return for hospital privileges, physicians are expected to donate between 150 and 200 hours a year to various MGH activities, such as the outpatient clinics, or as members of the visiting staff. These physicians may be compensated by the hospital for time spent over and above these hours, and, as subsequently discussed in more detail, professional fees earned from the care of teaching service patients have been used as a source for such compensation.

Visiting staff

At MGH the supervisory and teaching physicians in the teaching service section of the hospital have been designated as the visiting staff and are responsible for (1) supervising the care furnished to service patients by the interns and residents and (2) teaching the residents, interns, and medical students. Usually these visiting physicians have designated tours of duty on the teaching service of the hospital of 1 calendar month at a time. At the end of each month, exchange rounds are conducted, during which visiting physicians who have completed their tours of duty relinquish the responsibilities to the physicians beginning their tours.

The visiting physicians are assigned to the various medical and surgical areas of the hospital, such as medical, general surgery, children's service, orthopedics, and urology. For example, 24 visiting physicians covered the service areas during the month of March 1970.

We discussed the duties, responsibilities, and working routine of these visiting physicians with the hospital's chief of medical service. He informed us that the visiting physicians made rounds from about 10 a.m. to 1 p.m. 6 days a week, during which they, together with the residents and interns, examined patients. The visiting physicians also provided supervision and oversaw the medical care being rendered. They were on call for emergencies at other times. The chief stated that they generally devoted, on the average, 45 minutes to each new patient admitted to the hospital during the preceding 24 hours.

At the invitation of hospital officials, we accompanied a visiting physician, a resident, and two interns on their medical service rounds which took about 3 hours. Medicare and non-Medicare patients were housed in the same wards. The degree of the visiting physician's involvement varied considerably from patient to patient. Some patients were not in bed at the time of the rounds and thus were not seen by the visiting physician. Other patients were carefully examined, particularly if it was the first time the visiting physician had seen them, but still others were passed with a nod of acknowledgment. The visiting physician discussed all patients with the resident and interns. We observed that the visiting physician did not make notations in the medical records.

The chief of surgery stated that the involvement of a visiting physician on the surgical service in the care of inpatients varied. He added, however, that Medicare part B was not billed unless (1) the visiting physician was present during surgery, (2) his presence was considered necessary, and (3) he participated in the preoperative and postoperative care of the patient.

MEDICARE PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS

Policy of MGH

In a letter dated October 30, 1967, to the visiting physicians, the director of MGH announced a policy, approved by the MGH board of trustees, concerning the collection of fees from third-party insurers by such physicians for services rendered to teaching service patients. The director described the policy as a somewhat radical departure from practices existing at MGH at that time but stated that he thought it desirable in order to cope with the changes evolving in the structure of medical care in teaching hospitals brought about by recent social legislation.

Each visiting physician was given an option of (1) certifying to MGH that a billable professional service had been rendered and preassigning the fee to MGH, (2) electing to not certify, or (3) collecting the fee for his personal use. The director stated that the MGH general executive committee felt that it would not be in the best interest of MGH, its patients, or the public at large if the visiting physicians elected to collect the fees for their personal use.

Physicians who elected to certify a professional fee were requested to sign an assignment of their fees, as follows:

> "I, as a member of the M.G.H. Service, hereby voluntarily assign to the Massachusetts General Hospital all professional fees collected from teaching service patients in my behalf. This agreement is to be effective until terminated by me or by the hospital by written notice to the other, given at least sixty days prior to date of termination stated in the notice."

According to MGH officials, about 300 visiting physicians elected to assign to MGH their fees for services rendered to teaching service patients. We found no instances in which visiting physicians had charged Medicare part B for services to teaching service inpatients included in our sample without preassigning the fees to MGH.

MGH officials acknowledged to us that it was difficult to distinguish between teaching services and patient care provided by visiting physicians in a teaching setting. The director of MGH advised us that it was the responsibility of the visiting physicians, by exercising judgment on a case-by-case basis, to decide the extent to which their services justified fees.

Not all Medicare patients billed

The MGH comptroller advised us that MGH did not bill Medicare for the services provided by visiting physicians to all Medicare patients in the teaching service section of MGH. The comptroller suggested that Medicare was billed professional fees for perhaps only one third of the Medicare patients. Our review confirmed that all services of visiting physicians provided to Medicare patients in the teaching service section of MGH had not been billed for by the hospital. This seems to indicate that physicians did use discretion in deciding which Medicare patients in the teaching service section would be billed.

Our analysis of MGH admission data for the 1-week period August 18 through August 24, 1969, showed that 60 patients eligible for part B benefits had been admitted to the teaching service section of MGH. As of March 26, 1970, the hospital had billed only 18 (30 percent) of the 60 patients for services of visiting physicians.

There were various reasons why Medicare teaching service patients were not charged fees under part B. According to MGH officials, the services rendered in some instances clearly did not meet the criteria for reimbursement under the Medicare program. For example, in minor surgical cases only residents were present during the surgery. In other cases, either the chiefs of the services or the visiting physicians did not believe that fees should be charged for the type of services rendered.

PATIENT CARE IMPROVEMENT FUND

Effective October 30, 1967, MGH established the Patient Care Improvement Fund to accumulate the professional fees collected by MGH for services provided by visiting physicians and

for related ancillary services, such as radiology and electrocardiography.

It is the policy of MGH that service patients are not expected to pay ~~for~~ professional fees. Fees are collected, however, from third-party insurers. Also it is the policy of MGH to not collect the $50-deductible or the 20-percent-coinsurance amounts from Medicare service patients.

From its inception through September 30, 1969, $580,000 was deposited into the fund, of which about $470,000 represented Medicare part B payments and about $110,000 represented payments from other third-party insurers for surgical services.

Source of Receipts of
Patient Care Improvement Fund
through September 30, 1969

	Total	Medicare part B	Other third-party insurers
Inpatient services:			
Medical	$156,000	$156,000	$ -
Surgical	250,000	140,000	110,000
	406,000	296,000	110,000
Outpatient services	33,000	33,000[a]	-
Ancillary services	141,000	141,000[a]	-
	$580,000	$470,000	$110,000

[a]About $116,000 of this amount represented transfers to the fund from Radiological Associates for the professional (part B) component of radiological services furnished to Medicare service patients. Of the remaining $25,000 in Medicare payments for ancillary services, $21,000 was for electrocardiograms, and the balance was for miscellaneous services furnished to Medicare patients.

MGH records showed that, of the $580,000 received as of September 30, 1969, about $332,000 had been expended for specific purposes--$246,000 for salaries to physicians,

$44,000 for salaries to clerical personnel and technicians, $32,000 for related fringe benefits, and $10,000 for other expenses.

The remaining $248,000 received by the fund was transferred to the general funds of MGH. The accounting treatment of these funds was similar to the treatment of unrestricted donations for which there is no requirement to reduce allowable costs under SSA's reimbursement regulations established for part A of the Medicare program. The $332,000 spent for specific purposes was not included as allowable hospital costs for reimbursement purposes under part A.

Of the $246,000 paid to physicians, about $186,000 was paid to 39 physicians who had assigned their fees to the fund and about $60,000 was paid to 14 physicians who had not made such assignments.

The general guidelines established by MGH for use of the money in the fund provided that (1) under ordinary circumstances, a physician would not be paid more than $7,500 yearly, (2) each physician who received salary support from the fund must have a written description of how his activities would help improve the professional care of the patients, and (3) payments for the improved care of patients would be made only for services of physicians in excess of the 150 to 200 hours a year that they were expected to donate in exchange for hospital privileges. The director of MGH informed us that there was no relationship between MGH's payments to a visiting physician from the fund and that physician's decision to bill or not to bill as an attending physician.

REVIEW OF MEDICAL RECORDS FOR SERVICES RENDERED BY VISITING PHYSICIANS

Our review of medical records of selected patients in the teaching service section of MGH indicated that the professional services for which Medicare payments had been made by Blue Shield to MGH for services of visiting physicians generally had been furnished by interns, residents, and in some cases medical students rather than by the physicians in whose names the claims had been submitted. Residents and interns are not authorized to bill on a fee-for-service basis under part B of the Medicare program, but, their salaries were reimbursed to MGH under part A of the program, which means, in effect, that the program could be paying twice for the same service.

We were informed by MGH officials that individual medical records did not fully reflect the actual involvement of the visiting physicians in the care of individual patients and that the medical records were not accounting records that purported to be the basis for billings for services. The rules of the board of trustees of MGH, however, indicated that a physician who rendered or supervised medical services should document these services in the medical records. Excerpts from these rules follow.

> "Medical Records: (a) A complete medical record shall be created for each patient. The Chief of the Service or Department concerned shall be responsible for seeing that this is done. The physician responsible for each individual patient shall record in the medical record notes of his own examination, opinion and recommended treatment."
>
> * * * * *
>
> "(d) An admission note shall be written by the responsible physician as soon as possible after admission. Within 24 hours he must record the patient's history, complete physical examination, summary and provisional diagnosis. If the history and physical examination are recorded promptly the admission note is unnecessary."

* * * * *

"(g) A brief summary of the entire case shall be dictated or written by the responsible physician upon discharge of the patient.

"(h) The attending physician shall edit, correct or amend and countersign the history, physical examination and summary written by members of the House Staff. He shall sign all clinical entries made by himself."

* * * * *

"(j) All operations shall be fully described in the medical record and signed by the operating surgeon."

SSA's April 1969 guidelines regarding part B payments for services of visiting physicians state that, to be paid, the physician's involvement "must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician."

MGH billings on behalf of visiting physicians were made payable to the Patient Care Improvement Fund for a range of services, including medical and surgical care rendered to service patients in MGH and various ancillary services, such as radiology. We reviewed selected payments totaling $11,243 made by Blue Shield from December 1967 to December 1969 to the Patient Care Improvement Fund for services provided to 55 teaching service Medicare inpatients and 26 Medicare outpatients (51 outpatient claims).

In compiling the results of our sample, we separated the data on the basis of service dates to determine the extent to which documentation evidencing that visiting physicians had been involved in rendering the specific services billed had increased with the advent of SSA's April 1969 guidelines regarding part B payments to visiting physicians. We used July 17, 1969, as our cutoff date, since that was the date when MGH distributed the guidelines to each chief of service and, in our opinion, should have implemented the guidelines. (See p. 36.)

Because of the technical nature of the data being examined, we were assigned a Public Health Service physician to assist us in our review. The following table summarizes the nature and number of services involved, as well as the amounts billed to and allowed by Blue Shield, for the billings we reviewed.

Inpatient and Outpatient Billings

	Occasions of service	Amounts billed	Amounts allowed by Blue Shield
Inpatient billings:			
Medical services:			
Initial medical care	36	$ 1,440	$ 925
Daily visits	746	7,560	7,440
Consultations	9	360	315
Total medical services	791	9,360	8,680
Surgical services requiring use of operating room	13	5,325	5,155
Total inpatient billings	804	14,685	13,835
Outpatient billings	51	510	510
Total	855	$15,195	14,345
Less deductibles and coinsurance payable by beneficiaries			3,102
Total payments reviewed			$11,243

Our findings are discussed in the following subsections.

Initial medical care

On admission to the teaching service section of the hospital, a patient was generally provided with initial medical

care which, according to MGH's guidelines, consisted of "a comprehensive diagnostic history and physical examination including initiation of diagnostic and treatment program and preparation of hospital records." For billing purposes, this medical care was classified as an initial visit and a charge of $40 was made for each of 36 of the 42 nonsurgical teaching service patients included in our sample. Generally Blue Shield allowed $25 for the initial visit. In each of the remaining six cases, a charge of $40 was made for consultation, instead of initial medical care, for the initial day of hospitalization.

The number and type of medical personnel identified as having been involved in rendering specific services during initial visits are summarized in the following table. In 18 of the 36 cases, the medical records showed that the visiting physicians in whose names the services had been billed were personally involved in providing the specific services billed. In most cases, more than one person was identified as having been involved in providing the same service. Therefore the number of medical personnel identified with the services exceeded the total occasions of service billed.

		Nonsurgical cases	
	Total	Service rendered on or before July 17, 1969	Service rendered after July 17, 1969
Occasions of service rendered and billed	36	16	20
Medical personnel identified in the records with the service:			
Visiting physicians same as identified on bill	18	6	12
Residents	51	21	30
Interns	25	8	17
Medical students	16	6	10
Records not signed or signature not identifiable	10	5	5
Total	120	46	74

In addition to describing the $40 initial visit fee, MGH's guidelines for setting reasonable fees, described the services covered by an initial visit fee of $20, as follows:

> "Initial hospital care, including initiation of diagnostic and treatment program and preparation of hospital records."

The two types of initial visits differed in that the visit for which a $40 fee was charged included a diagnostic history and physical examination. In all 36 claims reviewed, the charges for initial medical care were routinely billed at $40 each, instead of $20, even though the medical records indicated that residents and interns, rather than visiting physicians, had performed the diagnostic histories and physical examinations.

Daily medical care

The Medicare program was generally billed, for follow-up visits for each day of hospitalization after a Medicare patient's first day in MGH, which was covered by the $40 charge for the initial visit. For the 42 nonsurgical teaching service patients included in our review, the follow-up visits were usually designated as daily visits, and the charges were $10 a day.

Our review of the medical records prepared by physicians (visiting physicians, residents, or interns) showed that, for 117 of the 746 daily visits billed to and allowed by Blue Shield, notations indicating that physicians had seen the patients had not been made by any physician, resident, or intern. Most of the 117 visits were made to five rehabilitation patients. (See p. 18.) For the 629 visits which were supported by physicians' notations, the records for only 11 visits, or less than 2 percent of the daily visits paid for by Blue Shield, contained notations made by the visiting physicians who signed the claims.

The following table summarizes our review of medical records supporting charges for daily visits. For many daily visits, the records showed that more than one physician had seen the patients on the days for which billings were made.

Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

		Nonsurgical cases	
	Total	Service rendered on or before July 17, 1969	Service rendered after July 17, 1969
Occasions of service:			
Billed	746	357	389
Not supported by notations of medical personnel	117	110	7
Supported by notations of medical personnel	629	247	382
Medical personnel identified in the records with the service:			
Visiting physicians:			
Same as identified on bill	11	4	7
Other visiting physicians	16	6	10
Residents	538	209	329
Interns	519	170	349
Medical students	116	45	71
Fellows	52	14	38
Records not signed or signature not identifiable	40	17	23
Total	1,292	465	827

As indicated above, MGH medical records showed no material increase in visiting physicians' involvement in specific services provided to patients after July 17, 1969. In addition, we noted that, regarding charges for daily medical care, the hospital had other problems in complying with SSA's April 1969 guidelines.

Problems in complying with SSA billing requirements regarding continuity of care

In accordance with MGH procedures, the visiting physician on duty at the time of a patient's admission to MGH signs the Medicare claims forms when he completes his monthly tour of duty. The periods of hospitalization of 21 of the 42 nonsurgical patients in our sample continued into another month. Their Medicare claims forms were each signed by a visiting physician who was not on duty during the succeeding month and did not render any services (although the services may have been rendered by the next visiting physician who went on duty).

For example, a patient was hospitalized on October 29, 1968, and was discharged on November 16, 1968. The visiting physician on duty during October signed the Medicare claim form for daily visits at $10 each up to and including November 16, even though his tour of duty ended October 31. In four of the 21 cases, the visiting physicians signed the claims before the patients had been discharged, and in these cases it appeared that charges for daily visits had been added to the claims after they were signed.

In another case, we noted that the patient for whom an initial visit and 26 daily visits had been billed by a visiting physician in the medical service section of MGH had been transferred on the 13th day to the surgical section of MGH where he underwent an operation by a resident. There was no evidence to indicate that the physician in whose name services were billed had visited the patient during any of the time the patient spent in the surgical section of MGH.

In our opinion, the billings for visiting physicians' services in these 21 cases did not comply with SSA's April 1969 guidelines which state that, to be considered an attending physician, the physician must:

> "*** be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization."

In commenting on this point, the director of MGH advised us that, since the regulations did not clearly and explicitly require that the claims forms be personally signed by each physician performing services, he saw no conflict in the fact that continuity of care was provided by two physicians when the stay of a patient continued into the next month and another visiting physician assumed the duties.

We believe that, regardless of which physician signs the Medicare claims form, MGH and its visiting physicians involved in the care of service patients will continue to have problems in complying with the SSA billing requirements concerning continuity of care by an attending physician so long as the physicians' tours of duty are in no way related to the period of a patient's hospitalization.

Other questionable billing practices involving charges for daily medical care

We noted that, after the visiting physicians had described the services rendered on the claims forms and signed the forms, MGH clerical personnel had, in some instances, altered the amount of charges for services. The physicians cognizant of the services advised us that they did not consider such charges to be appropriate.

For example, one visiting physician signed five claims of $40 each for consultations. Without the physician's knowledge, each claim was altered to show a charge of $40 for initial medical care and a charge of $10 for each day the patient was hospitalized, which resulted in a total of $330 being added to the five claims.

Another visiting physician charged Medicare service patients for "long consultations" at $40 each. He viewed the type of service he was rendering as justifying one fee for a long consultation instead of separate fees for initial medical care and daily visits. Without his knowledge, a total of 74 daily visits at $10 each were added to five of his claims.

We brought these cases to the attention of MGH officials who attributed the alterations to clerical errors. They reviewed the claims submitted by the medical service department and found additional alterations for which overpayments had

been received. The overpayments totaling $3,056, including the overpayments which we brought to MGH's attention, were refunded to Blue Shield.

Another problem with MGH's billing procedures related to the lack of documentation to support the claims of the rehabilitation service. Almost all the 117 daily visits (see p. 14) which were not supported by physicians' notations involves five teaching service Medicare patients who had received care in MGH's rehabilitation service. The chief of the rehabilitation service informed us that there was no requirement in his service to include daily progress notes in patients' medical records. He stated that attending physicians, although not necessarily those who signed the claim forms, had visited the patients daily but had not documented many of these visits in the medical records.

MGH reported that, through September 1969, professional fees totaling $3,700 had been received by the Patient Care Improvement Fund for rehabilitation services, of which $3,600 was from Medicare. The claims for these services were all signed during April or May 1969 by the chief of the rehabilitation service although some of the services had been rendered as early as December 1967.

Consultations

MGH's schedule of fees includes a description of two consultation services: (1) "consultation requiring comprehensive diagnostic history and physical examination" with a fee of $40 and (2) "consultation requiring limited history and physical examination" with a fee of $20. Included in the cases we reviewed were nine consultations for which MGH had billed Blue Shield $40 each.

The number and type of medical personnel identified as having been involved in providing consultation services are summarized in the following table. In some cases, more than one person was involved in providing the services. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Consultation services rendered		
	Total	On or before July 17, 1969	After July 17, 1969
Occasions of service:			
Billed	9	2	7
Not supported by notations of medical personnel	1	-	1
Supported by notations of medical personnel	8	2	6
Medical personnel identified in the records with the service:			
Visiting physicians:			
Same as identified on bill	6	-	6
Other visiting physicians	2	2	-
Residents	1	1	-
Interns	1	1	-
Fellows	3	-	3
Total	13	4	9

As shown above, MGH's medical records indicated an increase in the billing physicians' involvement in consultation services after July 17, 1969.

Outpatient services

We reviewed the medical records pertaining to 51 outpatient claims totaling $510, which were billed to and allowed by Blue Shield under part B of Medicare. In 45 cases, the medical records indicated that the physicians who signed the Medicare billing forms had rendered the services. It appears that documentation in the medical records regarding outpatient claims was generally adequate.

Only Medicare was billed for professional fees, in addition to the hospital's clinical charges, for outpatient services. Medicare patients, however, were not billed for deductible or coinsurance amounts.

MGH representatives informed us that other third-party insurers were not billed for outpatient services because the insurers' agreements with subscribers did not cover professional fees for outpatient medical services. Inasmuch as Medicare accounted for only 14 percent of the MGH's outpatient activity and other insurers were not billed for these services, we believe that a question exists whether Blue Shield should pay professional fees under these circumstances, because it cannot be said that the charges are either "customary" or "prevailing."

Operating room surgery

For the 55 Medicare teaching service inpatients in our sample, the MGH billed for 13 surgical operations which required the use of MGH's operating rooms. Of the 13 operations, six were performed before July 17, 1969; the other seven after that date. The charges allowed by Blue Shield for these operations ranged from $100 to $750.

The medical records relating to the six operations performed on or before July 17, 1969, revealed that residents were identified as the principal surgeons; for five of these operations, the attending physicians who signed the Medicare billing forms were listed as assistant surgeons. The attending physician who signed the Medicare billing form for the

sixth operation was not identified in the medical records as either the principal surgeon or the assistant surgeon. This physician informed us that he recalled being present during the operation which was performed on June 2, 1968. Also MGH administrative records supporting this billing showed that the attending physician "supervised but did not scrub" during the operation.

The medical records relating to the seven operations performed after July 17, 1969, showed that residents were identified as the principal surgeons. In three of these seven cases, the attending physicians who signed the Medicare billing forms were identified in the medical records as the principal surgeons.

In summary, the medical records showed that, in all the 13 surgical cases we reviewed, the attending physicians were present during surgery. In one instance, however, the physician did not scrub. The medical records showed that residents were the principal surgeons in 10 cases. Both a resident and an attending physician were designated as principal surgeons in each of the remaining three cases. These statistics may be compared with the statistics on Medicare claims for private surgical patients discussed on pages 29 through 33. According to the medical records for these claims, attending physicians were principal surgeons in all six cases and residents were assistant surgeons in five cases. In the sixth case, the report of surgery did not list an assistant surgeon.

An MGH brochure, entitled "Internship and Residency in General Surgery," appears to support our conclusion, based on the medical records, that the involvement of interns and residents in surgery performed on teaching service patients is different from their involvement in surgery performed on private patients. Excerpts from this brochure follow.

> "During the internship year in general surgery, the intern places his major emphasis on the diagnostic workup of his patients, assistance at their operations and in their postoperative care. He is given major responsibility in each of these areas. He is also early introduced to the operating room as the responsible surgeon. In succeeding years his responsibility steadily increases. Surgical

operative responsibilities are experienced throughout the program and are not reserved for the final year."

* * * * *

"On the private services the house officer [intern or resident] carries major responsibility in the preoperative and postoperative care of patients of the team of staff surgeons with whom he is working. In most cases he functions as first assistant in the operating room in private surgical service cases."

We raise this distinction between service and private patients because SSA's April 1969 guidelines provide that, if the custom in the community is for the attending physician to perform the surgery on private patients, then the attending physician must also perform the surgery on service patients in order to be reimbursed for it.

With regard to being reimbursed for the attending physician's presence in the operating room, the SSA guidelines state that:

"*** if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role."

It appears therefore that the amounts billed for the 10 service patients who were operated on by residents, with attending physicians as assistant surgeons, should have been for duties performed as assistant surgeons and not for the full surgical procedures. According to a widely used relative-value study dealing with physicians' fees and the relative complexity of surgical procedures, the relative value of an assistant at surgery is no more than 20 percent of the value assigned to the surgical procedure.

In commenting on a draft of this report, SSA agreed with our position that reimbursement should have been limited to assistant surgeon duties and advised us that it had asked Blue Shield to obtain additional information on this matter.

MGH officials informed us that the medical records pertaining to these 10 operations were inaccurate. We were informed that, in all cases in which attending physicians had signed Medicare surgery claims, the physicians had met the criteria for reimbursement as attending physicians in a teaching setting. MGH officials also stated that Medicare had been billed for general surgical procedures only if the attending physician was present in the operating room and participated in the preoperative and postoperative care of the patient.

The chief of the general surgical service stated that it had been common practice to list the resident as the principal surgeon in the teaching service sector of the hospital if he participated in the operation under the supervision of an attending physician responsible for the operation. In some instances, he added, the attending physician may have performed the more critical phase of the operation, although the medical records did not indicate that fact.

The surgical services chief told us, however, that, in the private sector of the hospital, it was customary to list attending physicians as principal surgeons when they were present and responsible, regardless of their involvement in the operations.

MGH officials recognized that the medical records had not adequately supported their Medicare claims for surgery. They advised us that, in the future, the medical records for service patients would show the attending physician as the principal surgeon when he believes that his services meet the criteria for reimbursement as an attending physician, which, we believe, may result in merely a record change with no change in the extent of the attending physician's participation in the surgery.

MGH and Blue Shield comments

In regard to the lack of documentation relating to the services billed for 42 nonsurgical Medicare service patients, MGH officials stated that the medical records were not accounting records and did not adequately reflect the number of times attending physicians visited the patients. They stated also that, in the future, Medicare would be billed for initial medical care, daily visits, and consultation services furnished

to its patients only when adequate documentation appears in MGH's medical records supporting each individual charge. MGH has devised a form to be completed whenever an attending physician visits a patient.

In commenting on a draft of this report, the director of MGH stated that the lack of notations in the medical records did not mean that the services were not performed. He stated that it was difficult to see how we could report our observation that the visiting physician, whom we accompanied on his medical rounds (see p. 5), did not write into the medical records and then use the absence of such entries to imply that the services were not performed by attending physicians.

We accompanied one visiting physician on his medical rounds to gain some insight into his relationship to the interns and residents and to the patients. Although we noted that this physician did not write into the medical records, we could not, on the basis of this limited tour, conclude that attending physicians never write into the medical records, particularly in view of the notations in medical records of private patients. (See pp. 29 to 33.)

In commenting on the reimbursement for a full surgical fee where a resident was listed as the principal surgeon, the director advised us that our observations were in contradiction to the Code of Federal Regulations (20 CFR 405.521(b)) which states that, in the case of major and other complex and dangerous procedures or situations, the personal and identifiable direction of the attending physician must include supervision by him. The director stated that the code does not state that the surgeon must actually perform the surgery in order to claim reimbursement for full surgical procedures.

The code states also that a charge should be recognized under part B of the Medicare program only if the attending physician's services to the patient are of the same character, in terms of responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. As discussed previously in this report, our review of the medical records of MGH showed that, for operations on private patients, the attending physicians had been shown as the principal surgeons, whereas for operations on teaching service patients, the attending physicians generally had been shown as the assistant surgeons.

Blue Shield officials stated that, in a recent review of MGH's medical records, they had found that documentation of medical services was the same as we had described. Their review, which was undertaken in February 1970, revealed that, in cases of daily medical care, the notations by visiting physicians consisted, at best, of one note only. Blue Shield also found that surgery notes showed performance of surgical procedures by residents with attending physicians as assistant surgeons.

PATIENT INVOLVEMENT

The comptroller of MGH informed us that Medicare patients were not billed for the $50-deductible and 20-percent-coinsurance amounts when services had been rendered in the teaching service sector of MGH for either inpatients or outpatients. This was in accordance with MGH's policy of not charging teaching service patients professional fees because they did not have sufficient financial resources.

The patients were responsible for $3,102 of the $14,345 allowed by Blue Shield for the 55 inpatient and 51 outpatient claims included in our sample, because of deductible and coinsurance amounts. MGH, however, did not bill the patients for these amounts.

MGH officials advised us that, if they were physically able, service patients signed the appropriate Medicare claims forms at the time of admission. Of the 55 claims submitted in behalf of teaching service inpatients, only nine had been signed by the patients and 13 had been signed by patients' relatives; the remaining 33 claims had been signed by hospital employees.

We were informed by Blue Shield officials that appropriate notifications (Explanations of Benefits forms) were always sent to Medicare patients when claims were processed on their behalf.

DETERMINATION OF REASONABLE CHARGES AND AMOUNTS ALLOWED

Payments for physicians' services under part B of the Medicare program are made on the basis of reasonable charges. The Medicare law requires that, in determining reasonable charges, consideration be given to the customary charge of the physician performing the service and to the prevailing charge in the locality. SSA regulations provide that the maximum allowable charge be the customary charge or the prevailing charge, whichever is lower.

We found that Blue Shield did not follow SSA instructions concerning the evaluation of the reasonableness of the uniform schedule of charges adopted by supervisory and teaching

physicians. SSA's April 1969 guidelines outline the method to be followed by the insurance organizations (carriers) that make Medicare part B payments in complying with the reasonable charge criteria for charges made by groups of physicians, such as members of the Patient Care Improvement Fund, as follows:

> "Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved."

Blue Shield officials advised us that they had not complied with the above instructions because it was not feasible or practical to do so. Blue Shield stated that:

> "The customary charge profiles that were developed for the *** /Patient Care Improvement Fund/ were developed from data based on its own charges. It would not be feasible with Medicare or regular business to attempt to meld prior charge data of each physician who becomes a participant in this and other physician association groups to develop customary charge profiles. There are also added factors that would not make this melding practical since the private practice charges of a physician would invariably differ because of circumstances, i.e., expenses, geographic location, etc., from those charges made as a participant in the *** group."

The principal reduction in the charges allowed by Blue Shield was for initial medical care which generally was reduced from $40 to $25. Some small reductions were also made for surgical procedures.

In our opinion, Blue Shield, to comply with SSA's April 1969 guidelines regarding payments for services of supervisory

and teaching physicians, should have compared the charges on the uniform fee schedule used by MGH with the average reasonable charges which would have been determined if each physician were individually reimbursed for the services involved. The uniform fee schedule should then have been reduced for those procedures for which the average reasonable charges were less than the amounts that were proposed in the fee schedule. SSA advised us that it was pointed out to Blue Shield again in May 1970 that the appropriateness of MGH's fee schedule needed to be established.

In commenting on a draft of this report, the director of MGH stated that the fairest and most economical way to administer the system of charging fees for daily visits was to charge one daily-visit fee for each day a patient was hospitalized, regardless of the number of times the patient was seen in any one day or whether the patient was seen at all on a particular day.

He stated that the uniform fee schedule, which limited the fees a physician could charge "people of moderate means," initially had been established in the Baker Memorial Hospital division of the MGH in 1930 and had been carried over into the operation of the Patient Care Improvement Fund. He stated also that this practice was in accordance with the Code of Federal Regulations which provides that the amounts payable for services of physicians supervising interns and residents be determined in accordance with the criteria for determining reimbursements for services which the physicians render to private patients.

As discussed on pages 7 and 8, although the physicians performed similar services for both Medicare and non-Medicare patients, the non-Medicare teaching service patients were not charged for professional services (except for surgical procedures and related care). In our opinion, this factor should be considered by Blue Shield in determining the physicians' customary charges.

COMPARISON OF MEDICAL RECORDS
OF PRIVATE PATIENTS WITH
TEACHING SERVICE PATIENTS

To compare the information shown in the medical records of teaching service patients with that shown in the medical records of private patients, we reviewed the medical records of 12 Medicare private patients who were hospitalized in the Phillips House unit and in the Baker Memorial Hospital of MGH after July 17, 1969.

We found that the private patients' medical records contained documentation supporting that their attending physicians had personally rendered the services for which these physicians had billed the Medicare program. This differed from the situation in the teaching service sector of MGH where, as previously noted, very little documentation existed to show that visiting physicians had been involved in providing the specific services for which the Medicare program had been billed.

The rules of the MGH board of trustees also distinguished between private patients and teaching service patients in describing the role of the responsible physician. The rules of the trustees stated that:

> "The recorded final diagnosis in the medical record of each discharged Service patient shall be signed by the responsible resident of the appropriate Service under the supervision of the Chief of that Service.
>
> "For private patients it shall be the responsibility of the attending physician to sign the final diagnosis himself."

Of the 12 private Medicare cases reviewed by us, six were nonsurgical and six were surgical. The nature and number of services involved, as well as the amounts billed to and allowed by Blue Shield, are summarized in the following table.

Private Patient Billings

	Occasions of service	Amounts billed by physicians (note a)	Amounts allowed by Blue Shield (note a)
Medical services:			
Initial medical care	6	$ 80	$ 80
Daily visits	66	775	400
Consultations	4	120	120
Total medical services	76	975	600
Surgical services requiring use of operating room	6	3,150	2,720
Total	82	$4,125	3,320
Less deductibles and coinsurance payable by beneficiaries			756
Total payments reviewed			$2,564

[a]The total amounts billed and the total amounts allowed for initial medical care and daily visits did not include amounts relating to two initial visits and 23 daily visits for which claims had not been received by Blue Shield at the time of our review.

The number and type of medical personnel identified as having been involved in providing medical care to the six non-surgical private patients are summarized in the following table.

Charges For Medical Services

	Initial medical care	Daily visits	Consultations
Occassions of service billed	6	66	4
Medical personnel identified in the records with the service:			
Attending physicians:			
Same as identified on bill	6	39	4
Other attending physicians	-	16	-
Residents	1	21	-
Interns	2	18	-
Medical students	3	9	-
Fellows	-	3	2
Records not signed or signature not identifiable	-	5	-
Total	12	111	6

The differences, as shown by the records, between the involvement of the private attending physicians in the services billed Medicare for their patients and the services billed Medicare for teaching service patients are discussed in the following subsections.

Initial medical care

We found that, in all six nonsurgical private cases, the records indicated that the physicians who had signed the bills had rendered initial medical care on the first day of hospitalization. In contrast, in one half of the teaching service cases reviewed, the medical records did not contain any evidence that visiting physicians had rendered initial medical care.

Daily medical care

Medical records of these six private nonsurgical cases contained notations made by the patients' private physicians on 39 of the 66 days for which daily visits were billed

(about 59 percent of the time). Further, the medical records indicated that attending physicians, other than the patients' private physicians, had visited the six patients 16 times during the 66 days.

In contrast, there was documentation in the medical records showing, for teaching service patients in our sample, the involvement of billing physicians in only 11 of the 746 daily visits (less than 2 percent) for which the services of visiting physicians had been billed by the hospital. The medical records also indicated that visiting physicians, other than those who had signed the billing forms, had visited the patients on 16 of the 746 visits.

Consultations

Four consultation charges were included in the six nonsurgical private cases we reviewed. In all four instances, the records showed that the private physicians who had submitted the bills had been involved in rendering the services.

In nine cases, consultations for teaching service patients were billed by the hospital. Records indicated, however, that in only six cases had the visiting physicians who signed the bills been involved in rendering the services.

Surgical procedures performed in operating rooms

Medical records concerning six operations on private patients showed that attending physicians were the principal surgeons in every case. In five of the six cases, the physicians were assisted by residents. In contrast, in only three of the 13 surgical claims for teaching service patients was there evidence that the attending physicians had been the principal surgeons.

MGH and Blue Shield comments

We pointed out to MGH and Blue Shield officials the differences in the amount of documentation relating to physicians' involvement between the private cases and the teaching service cases.

MGH officials did not comment on these differences. In commenting on a draft of this report, however, the director of MGH advised us that the implication that the responsible resident of the appropriate service was the responsible physician for service patients was not true and that the statement issued by MGH on October 30, 1967 (see p. 6), recognized that the responsibility for medical care rendered to service patients was vested in the assigned visiting physician.

Blue Shield officials advised us that in their review they also had found that physicians' notations in private patient records were much more detailed than were visiting physicians' notations in teaching service patient records.

OTHER MEDICAL INSURANCE PROGRAMS
AND INDIVIDUALS PAYING FOR
VISITING PHYSICIANS' SERVICES

It was the practice of MGH to not bill teaching service patients who did not have medical insurance for professional fees of visiting physicians.

In commenting on a draft of this report, the MGH director stated that MGH had had an official policy from December 4, 1959, when voted by the hospital trustees, of charging professional fees for teaching service patients. At that time, it was expressly stipulated by MGH's trustees that this action did not alter the policy of MGH that all persons were welcome in MGH, regardless of their ability to pay, and that charges were to be adjusted in accordance with that ability. The director stated that it had quickly developed that only those with third-party insurance could afford such charges and that the cost of identifying, charging, and collecting from the uninsured patients was prohibitive.

We were also informed by the MGH comptroller that it was MGH's policy to bill all third-party insurers that would pay for the services of visiting physicians whenever, in the judgment of the individual physician, a service which warranted a professional fee had been rendered.

We found that, in practice, only Medicare patients who had part B coverage were billed professional fees for inpatient services; with the exception of surgical procedures

and related care, third-party insurers, other than Medicare, were not charged for comparable services.

From its inception through September 30, 1969, the Patient Care Improvement Fund received about $189,000 under part B of Medicare and minor amounts from the State Medicaid program[1] and the Medex plan (Blue Cross-Blue Shield complementary coverage) for professional services rendered to medical service inpatients and to clinical outpatients. No funds were received from other insurers or patients for comparable services.

Hospital representatives informed us that generally third-party insurers, other than Medicare, were not billed because non-Medicare insurance policies did not provide for honoring claims for hospital medical care for teaching service patients or for outpatient medical services. The MGH comptroller informed us that the hospital intended to continue its attempts to obtain more monies from third-party insurers other than Medicare. The comptroller stated that, in his opinion, Blue Shield should honor claims for professional services rendered to teaching service patients under its medical insurance policies.

He stated also that MGH planned to begin billing the State Medicaid program in the near future for professional services rendered to all recipients whenever the visiting physician believed that the service rendered by him met the criteria for reimbursement.

For surgical cases, we found that Blue Shield honored claims under its medical insurance policies whenever the attending physician had been in the operating room and had

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[1]The amounts received were minor and represented only the deductible and coinsurance amounts for those Medicare patients who were also eligible for Medicaid. MGH did not receive professional fees under the Medicaid program except for those Medicare patients who had this complementary coverage.

scrubbed to assist in surgery. Through September 30, 1969, the Patient Care Improvement Fund received about $140,000 from Medicare and about $110,000 from third-party insurers for surgery and related services. This $110,000 included about $85,000 from Blue Shield and $20,000 from other insurers, such as Aetna Life Insurance Company, Metropolitan Life Insurance Company, and John Hancock Mutual Life Insurance Company. About $5,000 was received under the Medex plan and under the Medicaid program for those Medicare patients who had this complementary coverage.

Policy of Blue Shield

Except for surgically related procedures, Blue Shield did not honor claims for inpatient medical services furnished to its subscribers who were teaching service patients at MGH. Blue Shield also did not pay professional fees for outpatient services.

We were informed by a Blue Shield official that one of the benefit conditions of its medical insurance policies was that professional fees be paid only for services rendered to private patients. A "private patient" was defined by Blue Shield policies as a patient with whom a physician or dentist has an express or implied contract to render services for a fee. Since service patients were not expected by MGH to pay for medical services if they had no insurance, Blue Shield considered that no contract, express or implied, existed between its subscribers who were service patients and the visiting physicians on MGH's teaching service.

Blue Shield did honor claims for surgically related procedures performed on its subscribers if the attending physicians were in the operating room and had scrubbed for surgery. Blue Shield officials could not explain the apparent inconsistencies in its policy, except to point out that the tradition of paying for surgery performed by interns and residents might stem from a recognition that it was necessary for these doctors to obtain surgical experience.

SUSPENSION AND RESUMPTION OF PAYMENTS FOR SERVICES OF VISITING PHYSICIANS

Blue Shield reported that on May 1, 1969, it received SSA's April 1969 guidelines which were intended to clarify and supplement the criteria that govern reimbursement for the services of supervisory and teaching physicians.

On June 27, 1969, Blue Shield mailed the guidelines to the 58 hospitals in Massachusetts affiliated with medical schools, including MGH. On July 17, 1969, MGH distributed the guidelines to each chief of service. Blue Shield officials informed us that they suspended all part B payments to the 58 teaching hospitals on August 11, 1969, pending an audit of claims at each of the hospitals to determine whether such payments were proper. An audit was made by Blue Shield at MGH on October 6, 1969.

We were advised by the Blue Shield officials who made the audit that they had not retained any workpapers and could not identify the Medicare patients whose medical records had been examined. The Blue Shield report on the results of the audit concluded that "the recordation at the hospital is fantastic" and "on each medical record there is complete documentation for all services rendered."

Blue Shield, apparently satisfied that visiting physicians at MGH were performing the services for which claims were being submitted under part B, resumed payments on October 10, 1969. According to Blue Shield officials, the audit consisted of examining patients' medical records relating to 100 "live" Medicare claims (current claims as they came in for payment).

The Blue Shield officials responsible for the audit told us that, at the time of the audit, they were not familiar with the organization of MGH (i.e., private sector and teaching service sector). Accordingly, in their selection of claims, particular attention had not been given to selecting claims from that sector of the hospital where the visiting physicians were performing supervisory and teaching duties.

Also these officials told us that they had examined mostly surgically related claims and did not recall examining

any nonsurgical claims. It appears to us that Blue Shield, in its audit of 100 selected live claims, may not have examined claims involving patients who were hospitalized in the teaching service sector of the hospital but examined only claims relating to private patients. This appears to be the most likely explanation of why the results of its initial audit differed significantly from ours.

About midpoint in our audit, we met with Blue Shield officials to advise them of the results of our audit to date (examination of 32 medical records), which were essentially the same as discussed in this report. We also pointed out that, by selecting claims submitted by visiting physicians who assigned their professional fees to MGH's Patient Care Improvement Fund, we had selected cases in which the services had been rendered to teaching service patients. Blue Shield officials advised us that, in future audits, they would use the same approach. In February 1970 Blue Shield made another audit at MGH and found essentially the same type of problems as we did in our review.

To further clarify the nature of documentation required for supervisory and teaching physicians to comply with SSA's April 1969 guidelines, on March 25, 1970, Blue Shield sent letters to the 58 Massachusetts teaching hospitals in which Blue Shield presented additional instructions for billing Medicare. Thus, about 1 year after the issuance of SSA's guidelines, Blue Shield issued its implementing instructions. In general, the Blue Shield instructions indicated that visiting physicians could submit part B billings only for those services that were substantiated by hospital medical records. The instructions stated that the records should include the teaching physician's personal notes and his signature or his countersignature on the resident's or intern's notes for each visit for which he submitted a billing to Medicare, provided that these services were rendered under his direct supervision.

Blue Shield stated that the above instructions were to be effective April 1, 1970. The instructions were silent regarding those claims that were submitted prior to April 1, 1970. Blue Shield officials advised us that they had not yet decided upon the propriety of past payments made to teaching physicians at the 58 teaching hospitals in Massachusetts.

Both Blue Shield and SSA officials told us that another audit of medical records supporting past claims would be made to determine the propriety of payments made to the Patient Care Improvement Fund prior to April 1, 1970. SSA also advised us that on May 19, 1970, it had recommended to Blue Shield that further payments to MGH be suspended until the carrier could establish that reimbursements were for covered services and at the proper rates. On July 15, 1970, Blue Shield again resumed payments for professional fees for surgical procedures and for outpatient visits but not for inpatient medical services.

In commenting on a draft of this report, the MGH director stated:

> "The MGH will of course comply with the intent of the Law, but it is our sincere belief that we have complied with the Federal Code. The exceptions taken by the GAO are based upon intermediary letters which have not been filed in the Federal Register and only represent a suggested interpretation of the Federal Code. The MGH received a copy of the principal letter in question *** [SSA's April 1969 guidelines] in July, 1969. The final implementing letter from our Part B Carriers was dated March 25, 1970, and received in early April, 1970.
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> "It is incomprehensible and indeed reprehensible that interpretative guidelines issued long after the fact could be applied retroactively or indeed applied at all when they do not conform to the Federal Code and have not been filed in the Federal Register."
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> * * * * *
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> "*** We would further suggest that any future interpretations of the law be filed in the Federal Register on a prospective basis in order that the financial stability of the teaching hospital be maintained."

Although MGH implied that SSA's April 1969 guidelines changed the basic ground rules regarding payments to

supervisory and teaching physicians, SSA has stated that these guidelines were merely intended to clarify and supplement the criteria for making such payments.

SSA's April 1969 guidelines were issued to the insurance organizations, such as Blue Shield, to clarify the situations under which they could properly make Medicare payments for the services of supervisory and teaching physicians. The guidelines were furnished by Blue Shield to MGH so that MGH would have the opportunity to observe the criteria under which such payments could be made.

The underlying purpose of the Federal Register Act (44 U.S.C. 1501) is to afford a basis for giving constructive notice of Government regulations. Where the regulations or guidelines of April 1969 were, in fact, placed in the hands of the persons or institutions regulated as was the case at MGH, such persons or institutions would be chargeable with knowledge of such regulations or guidelines from the time they received them and publication in the Federal Register would not be required.